Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 28001

		1- For State Registrar Certificate of Death	Reg	. No.								
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year										
Paculcal Examili	iei	Dena Manuel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	August 23,	4c. County of Deat	0123 hrs							
- M		Johns Hopkins Bayview Medical Center Baltimore										
Funeral Director		5. Social Security Number 2,12-96-7983 1.7 1 M 2 X F 3 2 Yrs. F Under 1 Year If Under 24Hr Months Days Hours Min	_	, 1980 Foreign	thplace (State or on Maryland ountry)							
ku h		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	 		10d. Inside City Limits							
daryland 28a-f show any Latonce.	اج	Md. Baltimore City			1 X Yes 2 No							
ith the Maryland 23a or 28a-f sho notified at once.	I Director	10e. Street and Number 6802 Eastbrook Avenue 10f. Zip Code 21224		U.S.A.	ntry?							
r death w	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Vidowed 1 Divorced of Fyes, Give Year 1 Yes 2 No 1 Yes 2 No	Specify Yes or No- o Rican, etc.)	White, etc.	ican Indian, Black, hite							
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of Business/	Industry							
within iene.	틹	12th 2 yrs. Wait Staff		Country	Club							
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	B	17. Father's Name (First, Middle, Last) James Petway 19a. Informant's Name/Relationship (Type, Print) 18. Mother's Name (First, Middle, Maiden Surname) Dena Mayles (Street and Number or Rural Route Number, City or Town, State, Zip										
Shoul Shoul	۱٩	William Manuel - Husband 7925 Gough Street										
다. 음 함 를 E	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or								
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place) AU 4 Donation 5 Other Specify: Bayview Crematory 2	gust 7,2012	Baltimor	e.Marvlan							
Salti emit. epartm nports ijury o	ı	21. Signature of Funeral Service Licensea M00933 22. Name and Address of Facility ac	zorowsk	i Funera	1 Home, PA							
Physician	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Md. 21222 Approximate Interval							
/Medical examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Fatty Liver Due to (or as a consequence of):	-	, 511051, 5111051	Between Onset and Death							
*	.	Sequentially list conditions, b										
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Clinears as injury the bilitated										
760, crate be executed physician and the burial - transit	Examiner	events resulting in death) Last Due to (or as a consequence of): d.										
be execution a	Medical	x UNPENDED x AMENDED 23a, pt. II, 27, per me, g933 11-29 5 per fh g934 12-19-12 vt	-12 sm									
68760, ertificate be ding physic e as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery	v Day Year							
Box 687 re death certifi the attending ted for use as the	Physician	1 Yes 2 No 9 ✓ Unknown 9 Unknown 9 Unknown 9 Unknown										
ires that the d	e P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism		acco use contribute to								
ords, aw requir has been s 2 should	Completed by		24a. Was an		topsy findings available							
tal Reco	Ē		perform 1 ✓ Yes 2	ed? death?	_							
Vital F ysician: 7 ysician: 7 director, fi	Be C	25. Was case referred to medical examiner?	only one)									
ing Physical Chicago I of Vila	의	1 Yes 2 No No Inspiral 1 Inpatient 2 FR/Outpatient 3 DOA Norsin	ng Home 5 Re	esidence 6 Other	***							
Division of Vital Records, tal or Attending Physician: The law require reafter death. al Director: After this certificate has been side in by the finneral director, page 2 should be an order.	ation:	Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str or Town, Sta		ral Route Number, City							
Fo the Ho vithin 24 !	gelcal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.										
	Σ	29b. Signature and title of certifier Theodore III. The Theodore III. The Theodore III. Theodore III. Theodore III. The Theodore III. Theodor		29d. Date signed (Mo	nth, Day, Year)							
		30. Name and address of person who complete clause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B	saltimore, MD	21223								
Sta		31. Date filed (Month, Day, Year) SEP A A 2012										

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Arthur Lee Norman 2012 2:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 578-16-0658 Director 1 X M 2 □ F 90 March 20, 1922 Virginia Usual Residence of Deceden or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 5105 Newport Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black. White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0wner Retail Hearing Aids e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other i or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any Injury or other traumatic. Samuel Norman Jennie Longest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5105 Newport Avenue, Bethesda, Maryland 20816 Linda J. Norman /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛛 Burial 2 🗌 Cremation 3 🗌 Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 2012 21. Signatur of Fun - Service icensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Mar M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part 1. When the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: ျ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SANDEEL SHAMMA 970/ Vers 0 SANDERP Veis 0-. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 Sylvia S. Oster 2012 10:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Columbia Howard County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Min. Director 212-01-8805 1 □ M 2 🗓 F 3-6-1919 Maryland permit, Page 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any Injury or other treumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Howard County Columbia 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6005 Majors Lane #8 21045 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barney Schwartz Rebecca Snyderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10165 Goodin Circle Columbia, Maryland 21046 Frona Dubin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns. 8-30-2012 Falls Church, Virgina Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIOPULMONARY HRREST Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VENTRICULAR Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ate has been signed by the a page 2 should be detached Certificate: To Be

To the Hospitel or Attending Physician: The lew requires that the death certificete be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

9 Unknown	9 Unknown	au o 🗆 outor (Spoolify)		,
Part II. Other significant conditions of DEBILITY	contributing to death but not result	ting in the underlying	g cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 📈 No	Hospital: 1	R/Outpatient 3 1	ome 5 Residence	6 D'Other (Specify) HOSPICE	
27. Manner of Death 1 N Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	8b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred
3 Suicide 6 Could not be 4 Homicide determined		ne, farm, street, facto	ry, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
(Check 2 L Medical Exam	sician: To the best of my knowled iner: On the basis of examination a se Practitioner: To the best of my	and/or investigation, in	n my opinion, death occurred a	at the time, date and place	e, and due to the cause(s) and manner state

29c. License number

ANE

D72139

COLUMBIA

ugusi 29th 2012

State Registrar

completely

Medical

only one) 29b. Signature and title of

ABBAS

CEDAR

MI

32. Registrar

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28005 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert A. Price, Jr. Physician/ Month 2:55 P 2012 Medical August 30. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, Year)
September 28,1927 Sparks, Maryland 216-28-7067 **Director** 1**X**XM 2 □ F 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merdal Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Baltimore Sparks 1 Yes 2 No 10e. Street and Number 15035 Priceville Road 10f. Zip Code 10g. Citizen of What Country? Funeral 21152 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mailman U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert A. Price, Sr. Helen Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corinne C. Price (Spouse) 15035 Priceville Road Sparks, Maryland 21152 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel—Bel
Air 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State September 05, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Name and Address of Eacility
Evans Funeral Chapel & Cremation Services—Monkton <u>16924 York Road Monkton, Maryland 21111</u> 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ days Medical **Examiner** Fibrillahon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 LINO To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 \sum Yes 2 \sum No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit D0063904 8/30/12

Registrar DHMH 17 Rev 06-2011 Joh

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lton Robert Pr		s, Jr amend (Gate Por Mary land) Department of Certificate of	Health and Mental I Death		g. No. 2012 2800
Physicia edical Exami	in/	1. Decedent's Name (First, Middle,Last) Milton Robert Provins, Jr.		2. Date of Deat Month August 16	Day Year 0045 has
			b. City, Town, or Location of Dea Glen Burnie		4c. County of Death Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M	in.	h(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	ı	214-58-6327 1 M 2 F 62 Yrs. Usual Residence of Decedent		01/19	/1950 Country) MD
w any		10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits 1 Yes 2 X No
uryland la-f sho	cto	MD Anne Arunde1 10e. Street and Number	Glen Burn:		Og. Citizen of What Country?
the Ma	Director	7969 Cross Creek Drive	21061		U.S.A.
ath with items 2.	Funeral	1 Never Married 2 x Married Armed Forces? If Ye	s Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Puer		- 14. Race - American Indian, Black, White, etc.
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	or Dates:	Yes 2 X No specify:		Specify: White
5 72 hours in "natu	eted		t's Usual Occupation (Give kind o ost of working life. DO NOT use re		16b. Kind of Business/Industry
5-0036 iled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	Chemist	ne (First, Middle, N	Chemical Asiden Surname)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medical</u>	Be	Milton Robert Provins, Sr.	Marie	. F	Rokozy
MD 2121. 2 should be fi h and Mental 1 27 is marked matic event,	၉		Address (Street and Number of 69 Cross Creek		sber, City or Town, State, Zip Code) Glen Burnie, MD 21061
re, M 1 and 2 1 Health fitem 2			tion (Name of cemetery,	Date	20c. Location - City or Town, State
Baltimore, bermit. Pages 1 an Department of Heal important: If iten		4 Donation 5 Other Specify: Atlantic			Glen Burnie, Marylan
Bal permi Depar Impo		Mak a. Van Moi357 Si	ngleton Funeral	2nd Ave & Crema	tion Services, P.A.
Physician \/Medical		23a. Part. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arre	est, shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) e. Hemopericardium Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate b. Rupture of Aortic Dissection Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last use to (or as a consequence of):			
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical E	d			
'60, ate be e	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
K 6876(n certificate ending phys use as the b	cian/	past 12 months? 4 Pregnant at time of death 5 Oth	al death 3	nancy	Month Day Year
m a sal	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
— % .50 e	ē			1 Yes	2 No 3 Probably 4 Unknown
of Vital Records, ag Physician: The law require this certificate has been si meral director, page 2 should t	Completed			24a. Was a autop perfor	
T		25. Was case referred to medical	26.Place of Death (Chec	1 Yes	
Vital hysician: this certif	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			Residence 6 🗸 Other: Scene
ion of tending Pheath. tor: After the funeral		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of In	njury 28c. Injury at Work?	28a. Describe r	now injury occurred
ivis or At after d Direc	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree	t, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Rural Route Number, City tate)
Hospital 24 hours Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr	red at the time, date and place, a	nd due to the caus	e(s) and manner as stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.	ion, in my opinion, death occurred	d at the time, date	and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	2	29b. Signature and title of certifier	O.C.M.E.		August 17, 2012
		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W	Raltimore Street Raltim	ore MD 2122	23
S	ate				
Regis		SEPU 4 ZUIZ KARANA			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29 Day 2012 Year Gajanand Pathmanathan 10:13 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10913 Orleans Way Kensington Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 017-62-6332 1 X M 2 □ F 58 Yrs. January 23, 1954 Sri Lanka Usual Residence of Decedent in then "naturel", or items 23e or 28a-f show the Medical Examinational be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery 1 Tes 2 X No Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 10913 Orleans Way 20895 Sri Lanka 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 ☐ Yes 2 X No 1 ☐ Yes 2 🖾 No Specify 3 Widowed 4 Divorced If Yes, Give Completed Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Manager World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Welayuthan Pathmanathan ge 1 end 2 should but of Health and Mer it of Health and Mer : If Item 27 is mark Sundareswary Coomaraswamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dhamayanthy Pathmanathan / Wife 10913 Orleans Way, Kensington, Maryland 20895 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Importent: If It eny Injury or o Montgomery Crematorium, Inc. September 2 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funeral Sarvice Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pancreatic Adenocarcinoma years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir ause (Disease of injury or Attending Physicien: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Month Day Year detached g 🗌 Unknown ý Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed, page 2 should be de 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has prior to death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien:
 24 hours after death,
 Funerel Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မှု 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury М 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

State

within 2 To the I

29b. Signature and title of certifie

Amy Dezern,

31. Date filed (Month, Day, Year)

MD

32. Registras Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

4 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1650 Orleans Street # 186, Baltimore, Maryland 21287

D67193

August 30, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0ren L. Ra1ston 2012 5:00 p Medical August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Golden Living Nursing Center Westminster Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

July 14 1920 Birthplace (State or Foreign Country) **Funeral** Days Hours 92 579-07-3567 1 ₹ M 2 □ F **Director** MD iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 Sykesville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6514 Ridenour Way Funeral 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", Specify: white Completed 3 Widowed 4 Divorced Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) automotive autobody worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oren Ralston Rey Williams Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Hazel Ralston (spouse) 6514 Ridenour Way, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date All County Cremation 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-31-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Para sparght Herbert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition weeks Medical resulting in death) Due to (or Examiner Sequentially list conditions, Due to (or if any, leading to immediate attending physician and for use as the burial-transit Cause (Disease or injury that initiated events anceo resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year be detached 9 Unknown g | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 Fortunation after death.
5 Euneral Director: After this certificate has letely filled in by the funeral director, page 2 perform Hospital or Attending Physician: The Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the F only one 29d. Date signed (Month. Day. Year) who completed cause of death (Item 23a) (Type, Print) Poole Road Westminster 688C Trace

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Marylan	d / Depa	artmen	t of He	ealth ai	nd Me	ental Hy	giene			ı	
		1 - State Registrar Certificate of Death Reg. No. 20 2 28														2
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	Examin		4a. Facility Name (if not institution,				4b. City,	Town, or L	ocation of	Death			County of Dea			
			Medstar Montgon				01n	,	If Under 24	4 ∐re	8. Date of Birt		Montgo		e (State or Fore	eian
	Funeral			6. Sex 1 □ M 2 X F	7. Age (In yrs. Ia		Months		Hours	Min.	(Month, Da	y, Year)	Co	untry)		agn
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	and show	호	10a. State 10b. County			, Town or Loc								10d	Inside City Lim	
	Mary 28a-f otifie	Director	MD Montg	gomery	Roc	kville									1X Yes 2] No
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	be filed within 72 hours after death with the Maryland kental Hygiene, kental Hygiene, and "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	Funeral	13821 Bauer Dri		edent Ever in U.S	13 V			panic Origi	in? (Spec	ify Yes or No-		14. Race - Am			
	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed Fo	orces? No 196	50	Yes, spec	cify Cuban,	, Mexican,	Puerto R	ican, etc.)		Black, Whi			-
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0	be file ental ked c	은	Leon Rosenzweig						Sy:	lvia	Feldma	an				
d y	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh	nip (Type, Print)									Town, State, Z		le)	
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DIVISION	er deg ector by th	Certificate:	3 Suicide 6 Could 4 Homicide determ	ained 28e, Plac	e of Injury - At h	ome, farm, str	reet, facto	ry, office		2	28f. Location (d Number or F	ural R	oute Number,	
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	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	ledical	(Charle 2 Madical I	g Physician: To the Examiner: On the ba	seie of evamination	in and/or inves	stigation, in	n my opinio	n. death oc	curred at	the time, date	and place.	, and due to th	e caus	e(s) and manner	stated.
	the latter of th	ž	only one) 3 Certifying 29b. Signature and title of certifie	g Nurse Practition	er: To the best of	my knowledge		curred at tr		e and pla	ce, and due to		te signed (Mor			
5	F 3 F ö		12		D		I	00	587	770		0	1281	12	-	
	,	ļ	30. Name and address of person			n 23a) (Type,	Dutual									
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	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ture										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27,2012 AŰĞÜST 3:00P M CORRIE BELL REICH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MANOR CARE ROSSVILLE ROSEDALE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** CAROLINA 1 🗆 M 2 🕱 F Days Months Hours Min. 12-17-1931 80 Yrs. **Director** 242-44-3198 ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director MD BALTIMORE ROSEDALE 1 Yes 2 Xo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6738 FORDCREST ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 1950-53 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o MARK BELL MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK REICH/HUSBAND 6738 FORDCREST RD ROSEDALE, 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State # 5 permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 8-31-12 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature Fun ra Servi e Licensee 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ GMENTA Medical resulting in death) Due to (or as a consequence of): Examiner wite wints Sequentially list conditions cause. Enter Underlying Exami ntimo walning Allinta the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed **Director:** After this certificated in by the funeral director, pag 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🕱 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, dpath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier GUNG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 filed (Month, Day, Yea State SEP 0 4 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 2012 26 Alyson Sue Rice 10:11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 24 Hrs Days Hours 158-46-3265 1 □ M 2 **X** F 52 9-17-1959 New Jersey 10c. City, Town or Location 10d. Inside City Limits Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6111 Montrose Road #1002 20852 United States

ms 23a or 28a-f shov must be notified at filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

Physician/

Medical

Director

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MD

Examiner

Funeral

Director

Ph_sician/ Medical **Examiner**

21/92

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To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Alyson

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by Fun		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No		Decedent of Hispan s, specify Cuban, Me	ic Origin? (Spe exican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
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-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailing A	ddress (Street and N	umber or Rurai	l Route Number,	City or Town, State, Zij	o Code)				
	Cindy Sawyer - Si	ster	615 Vi	a Santa P	aulo, V	Vista, C	alifornia	92081				
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7	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the unde	rlying cause given in	Part I.	23e. Did tob	acco use contribute to	the cause of death?				
сотріете ву						1 □ Ye	s 2 ZÎNo 3 □ P	robably 4 🗆 Unknown				
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E						24a. Was an autopsy perform	/ Prior to (topsy findings available completion of cause of				
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2	1 Yes 2 No	1 Inpatient 2 🗆 i		LI DOA 4			nce 6 Cother (Spec	ify)				
cermicate	Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? VI 1 ☐ Yes		28d. Describe hov	v injury occurred					
i e	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street,	actory, office	2	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,				
g	00- C-46 4 V C 44	die Telle Leiter	-111				()					
Medik	(Check 2 Medical Examination	cian: To the best of my knowle er: On the basis of examination e Practitioner: To the best of m	and/or investigati	on, in my opinion, dea	ath occurred at	the time, date and	place, and due to the	cause(s) and manner stated				
	29b. Signature and title of certifier	- AA	^	29c. License num	ber		d. Date signed (Month					
	1 For	-0 //	1	660	64		US/ E7	112-				

State Registrar

8600 Old Georgetown Road, Bethesda, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babak Pirouz, MD -

31. Date filed (M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen C. Robinson 1020 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 219-40-8710 (Month, Day, Year) Director 1 🛛 M 2 🗆 F 69 Maryland June 6, 1943 r then "natural", or Items 23a or 28a-f show the Madical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director **Florida** Charlotte Alva 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 18200 Elmwood Drive 33920 USA Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Md. Dept. of Public Works Laborer Be 17. Father's Name (First, Middle, Last) Page 1 and 2 should be filed tment of Health and Mental H tant: If Item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Sidney Robinson Krammel Katherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Robinson (Brother) 18200 Elmwood Drive, Alva, Florida 33920 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. 4 Donation 5 Other (Specify) 9/7/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. MO0175 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Artenis sclenitic Vaszular Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificete be execute within 24 hours efter death.

To tha Funeral Director: After this cartificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstructive 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Déen Venou 1 ☐ Yes 2 Ø No Yes 2 [25. Was case referred to medical examiner? Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗆 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nt Agnes 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ 12:00 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number , or Location of Death Examiner Wildingo 00 17 A ore. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. lagt birthday) **Funeral** Months (Month, Day, 0 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr Funeral \mathbf{Z} vildword 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married <u>م</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ack 3 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5#) the wall Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stolle ဂ္ဂ trneathe 1.00 daughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) StoKes Balk, md, 2 701 1au W Wood other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 2012 Woodbine 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3405 (ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ding, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ metastatic 1090 Medical resulting in death) Due to (or as a consequence of): ear Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ed by the a g Unknown g 🗌 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by • Hospital or Attending Physician: The law requires to 24 hours after death.
• Funeral Director: After this certificate has been sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 L 3 L Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Balt, ThD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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<u>ya</u>	and Mental Hygiene. Is marked other than raumatic event, the Ms	잍	MARION		OHNSO	<i>N</i>						ETTH		PROC			
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Baltimore,	ant of ht: If it y or o		1 Burial 2 ☐ Cri 4 ☐ Donation 5 ☐	remation 3 🗌		- 0	cemetery, cren	natory or	other place	e)		1,2012			•		10.
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Division of Vital Records, P.O. Box 6876(Hospital or Attending Physician: The law requires that the death certificate	been signed by the attending phys should be detached for use as the	by P	Part II. Other significant	conditions co	ntributing to death b	ut not res	sulting in the u	nderlyin	g cause giv	en in Part I.		23e. Did to	obacco	use contribu	ite to the	e cause of o	death?
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Hosp	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 ☐ M	ledical Exemin	ician: To the best of Tex On the basis of e	xamination	n and/or invest	igation, i	n my opinio	n, death occu	urred at th	e time, date a	and place	, and due to	the cau	se(s) and ma	anner stated.
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	5		30. Name and address of			eath (Item	23a) (Type, P	rint)		Λ ,		0	1-	2.6		0 3	2 - 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #27, 28A-F, PER ME, G954 8-13-14 SM State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ STEDDING AWOnth 10:10 AM LEONA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 215-01-7963 Director 1 M 2 DXF 92 Sept 27 1919 MD Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23e or 28e-f show eny lijury or other treumetic event, the Medical Examiner must be notified at once, once, once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Sykesville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1500 Sykesville Road 21784 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\sum \) Yes 2 \(\sum \) No 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) turf farm owner agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Charles Bollman Henrietta Heiland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William M. Stedding (son) 301 Anna Lane, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify)entombment 8-31-12 Marriottsville, MD Crest Lawn Mausoleum 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Harel MO0764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or compiler tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY Physician/ VALVULAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CENTRICATION APPROVED BY MEDICAL EXAMINA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien end I for use as the burial-trensit The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day signed by the eld be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FRACTURE LEFT SUPERIOR +INFERIOR 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 🗷 No 1 ☐ Yes 2 ☐ No ours after death.

• rel Director: After this certific: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: 1.2ATYes 2. □ No Other: မှ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospitel or Attending 5 Pending injury SUBJECT FELL 1 Yes 2 X No 2 X Accident
3 Suicide
4 Homicide Investigation 8-28-2012 UNK **A**M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1500 SYKESVILLE RD. SYKESVILLE, MD. determined HOME Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00033768 28 AUG , 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LORWIN MD 755 LEVAR LN CULUMBIA MO 21644

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

SEP 10 4 2012

21215-0036

Baltimore,

Box 68760

P.O.

Vital

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Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 28 2012 8:12 PM Albert Herman Sherman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Medical Center Montgomery 01ney 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 141-16-9979 **Director** 1 🕅 M 2 🗆 F 91 3 - 5 - 1921Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City. Town or Location notified at Director FL 1X Yes 2 ☐ No Aventura Dade 10f. Zip Code 10g. Citizen of What Country? ŏ permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral United States 20100 West Country Club Drive #504 33180 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2X Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Research Chemistry Organic Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothy Shanefield Irvin Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9437 Reach Road, Potomac, Maryland 20854 Nancy Shapiro - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 8-31-2012 Clarksburg, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction Signature of Funeral Service Licensee Brad Smetzer Sud 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardiovascular Disease Atherosclerotic year) disease or condition Medical resulting in death) **Examiner** yeurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🗌 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Yes Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No

Box 68760 P.O. Hospital or Attending Physician: The law requires Division of Vital Records, s after death filled in by the 24 hours within 24 hou

To the Fune

completely fi

State Registrar

colney, Marylana 31. Date filed (Month, Day, Year) 32. Registrar's **SEP 0 4**

Medical

1 Natural

4 Homicide

29a. Certifier

(Check

only one)

Accident Suicide

3 🗆

5 Pending

Investigation
6 Could not be

determined

Mullichresen

Phillip

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0028429

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phyllis Nichelson, MD

DriVL

Location (Street and Number or Rural Route Number, City or Town, State)

August

29d. Date signed (Month, Day, Year)

28,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death p 2. Date of Death Physician/ ^D28 2012 **EDWARD** STACHOWSKI J. AUGUST 6:35 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROSEDALE 1227 LANDOVER ROAD BALTIMORE Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 214 26 6625 Days Hours 07/28/1930 **Director** 82 MARYLAND 1 **X** M 2 □ F Yrs Usual Residence of Decedent or 28a-f show be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code r items 23a or ner must be r 10g. Citizen of What Country? Funeral 1227 LANDOVER ROAD 21237 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or ite Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 L**X**Yes Yes, Give 1 ☐ Yes 2 ☐No Specify: Specify: WHITE 3 X Widowed 4 Divorced KOREA Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) alth and Mental Hygiene.

27 is marked other than it traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) MILLWRIGHT AMERICAN CAN O Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ EDWARD STACHOWSKI SR. VERONICA NOVAK 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9105 TRANSOMS ROAD BALTIMORE, MD 21236 Health tem 27 STEVEN J. STACHOWSKI/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or of once. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HOLLY HILL MEM. 08/31/12 MIDDLE RIVER, MD 4 Donation 5 Other (Specify) 21. Signatur 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 6) Medical resulting in death) Due to (or as a con uence of) Examiner 5 199 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lue to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the attending physician and ched for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Funeral Director: After this certificate has autopsy Hospital or Attending Physician: The 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 Yes Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Accident 5 \square Pending 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

SEP 0 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Salaman Physician/ Month 11:15 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Baltimore, mD Haspital N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 4 Pearl 930 083-22-3195 New York Director 1 🛣 M 2 🗆 F Usual Residence of Decedent 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director must be notified Parkville Baltimore 1 Yes 2 XVo MD 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 21234 23a 7617 Perring Terrace USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2X Married 3altimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) filed within 7 tal Hygiene. VMF Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor 6 Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or ဂ္ Lewis Salzman Tsabelle Rice 19a. Informant's Name/Relationship (Type, Print) Department of Health and I st. Important. If item 27 is any injury or other traumonce. 19b. Mailing Address *Street and Number or Rural Route Number*, City or Town State 310 Codel 34 7617 Perring Terrace-Parkville, Mary Land 21234 Ruth Salzman-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel and Cremation Ser Be 20c. Location - City or Town, State Sept.2,2012 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 anden Fordol 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metabolic Encephalopathy disease or condition resulting in death) days Medical Examiner Adenocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation, Caronary Arten) Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No Hyperlipidemia 24a. Was an has autopsy performed Yes 2 certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Investigation filled in by the Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Bathmore, MI Eliason, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 29°, SCHEINER 2012 10:30 A M **JOHANNA** Klara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Baltimore Months Days Hours (Month, Day, Year) Director 215-30-1769 1 □ M 2 😿 F 78 Jan. 24, 1934 Maryland show or 28a-f shov notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Harford Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n ms 23a or Funeral 1664 Deep Run Road 21160 U.S.A. "natural", or items Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc Completed by 1 Never Married 2 X Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker 12 Be Page 1 and 2 should be filed of ment of Health and Mental Hycant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Kurt Schulz Rosalie Stenchen traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1664 Deep Run Road, Whiteford, Maryland 21160 Mr. Edward Scheiner (Spouse) Department of Healt Important: If item 2 any injury or other other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) September 1 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkville, Maryland 21. Signature of Funeral Service Licensee Jeffrey R. Testerman Evans Funeral Chapel & Cremation Services - Bel Air 2012 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CVA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2√ No 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifies completely filled in by the funeral director, 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 032-295 Chan = 3: 21, 247

Registrar

DHMH 17 Rev 06-201

State

DAVID DUNN

BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28020 Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Helen Szymanik 2012 7:25p M August 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-14-2883 Months Days Hours (Month, Day, Year, Director 1 🗆 M 2 🔀 F 89 Yrs. March 26, 1923 Maryland og other than "neturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1729 Stokesley Road 21222 USA 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 8 years Be permit. Page 1 end 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumette even 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanislaus Chetnik Valerie Chetnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Young Daughter 7228 Martell Ave. Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State September 4. Dundalk, Maryland Oak Lawn Cemetery ■ Donation 5 Other (Specify) 2012 fress of Facility
Funeral Home of Dundalk, P.A. Sollers Point Road, Dundalk, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Murocan Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician end ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day should be detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed this certificate 1 Yes Yes /2 25. Was case referred to medical Hospital or Attending Physicien: Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗷 No Other: ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death, 1 ☐ Yes 2 ☐ No filled in by the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours efter of Funerei Direc 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in morning to the cause of examination and/or investigation in morning. Medica 29a, Certifier To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

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TOUSON M

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ August 29, 2012 Year Sullivan Medical Kenneth 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Director 218-56-3174 1 XM 2 D F Yrs August 14, 1952 Pennsylvania 60 10a. State 10b. County 10c. City, Town or Location Director Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 5213 Lynngate Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examination Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Year or Dates. 1970-1974 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rernadine Burke Reardon Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5213 Lynngate Road, Columbia, Maryland 21044 Pav Govindasamy / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of August 31, 20c. Location - City or Town, State cemeter, crematory or other place)
Montgomery
Crematorium, Inc 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville D. 8pm 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cophagen disease or condition resulting in death) Medical Due to (or as a consoquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examin attending physician and I for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760 24 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 is autopsy performed? Yes 2 No ☐ Yes 1 TYes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 58303

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

8:20 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗆 No

nospice

Year

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1 Yes 2 No

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State

Registrar

N.

6701

Charles ST TOWSON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMMES

4 2012

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BARON

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 6:28AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bothesda Montgomer If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Min. Days Hours 133-05-6330 **Director** 1 M 2 K F 91 February 17, 1921 New York Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🕅 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 3704 Munsey Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Monee. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Perlmutter Yetta Perlmutter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 Scott Ave. Rockville, Maryland 20851 Dana Shapiro / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 4, 1 Durial 2 X Cremation 3 Removal from State Montgomery Crematorium 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphery Funeral Home Bethesda-Chevy Chase, Inc. - MO1662 7557 Wisconsin Ave. Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Acute injocarding Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypothyroidism Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29c. License number -2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chuanbo Zhang, Subluban H Suburban Hosp 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death Physician/ Month Day Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death BACTIMORE WASHINGTON MEDICAL GL BURNIK NNE VRUNDEL Social Security Number 6. Sex If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 217-34-3470 **Director** 1 🗓 M 2 🗆 F 74 07/01/1938 Marvland show with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 X No Linthicum Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Viewing Avenue 21090 U.S.A. death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. þ 1 Never Married 2 X Married X Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) injury or other traumatic event, the Attorney 8 Corporate Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isadore Sacks Rebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 si ment of Health a ant: If item 27 is Mrs. Mary Lou Sacks / Wife 303 Viewing Avenue Linthicum Heights, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Atlantic Crematory 09/01/2012 Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Lice MO1479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MYOCARDIA disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending plant for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OR. STEVEW HBERT 31. Date filed (Month, Day, Year) State Registrar SEP 0

HMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2/12 10:30 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner timer If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 212-26-0836 1 □ M 2 🕱 F Months Days Hours Min Feb 18, 1928 Maryland **Director** Yre Usual Residence of Decedent 28a-f show 10b County filed within 72 hours after death with the Maryland Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 1 Yes 2 No Baltimore 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21 East Fort Avenue 21230 TISA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Black, White, etc. "natural", or Sq. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 - Widowed 4 X Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk McCormack Spice Co. Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file
Department of Health and Mental F
Important: If item 27 is marked o
any injury or other traumatic eve ပ Frederick K. Margaret E. Sturgeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Airey (2nd Cousin) 304 Fifteenth Avenue, Brooklyn Park, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Mausoleum 9/4/2012 Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. cker 21. Signature of Funeral Service Licensee ACVIN E. M00175 130 East Fort Avenue, Baltimore, Maryland 21230-4513 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Wete Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner e lence of ension or as a consequence of resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Po in the past 12 months? Month Pregnant at time of death Yes 2 No is certificate has been signed by the director, page 2 should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural Accider 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/2 9 Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson 3 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

4 2012

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Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal	death	3 ☐ Ectopic p 5 ☐ Other (spe		/					te of delive	. ,	⁄ear
ds, P.O.	luires that the signed by all die detail	þ	Part II. Other signification	rations	ontributing to death bu	t not resu	_	e underlying c	ause give	en in Part I	i.					e cause of d	
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ion of \	Attending Physician: death. ctor: After this certific by the funeral director,		27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	28a. Date of injury (Month, Day,		28b. Time injur	e of 28	c. Injury work?	at	28d	5 ☐ Resid					
Divisi	• Hospital or Atten 24 hours after deat • Funeral Director: etely filled in by the		3 ☐ Suicide 4 ☐ Homicide	6 U Could not b determined	28e. Place of Injur building, etc.	y - At hor (Specify)	ne, farm,	street, factory,	office		28f.	Location (S City or Tow			er or Rural	Route Numb	er,
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5			30. Name and addre	ess of person who	completed cause of dea	ath (Item.	23a) (Type	e, Print)	L	b Wit	400	13	11	mil			
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Smith Donald

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Box 68760	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Completed by Physician/Medical			d												
89	certif ending	N/u	IF FEMALE: 23b. Was decedent		23c. If yes, outco	ome of pregn	ancy	Tectonia	c pregnanc	V			4	23d. Da	ite of deliv	ery	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certificate:	29a. Certifier 1	Certifying Phy	sician: To the her	et of my knov	vledge death	occurred	at the time	data and	place a	ad due to the	20100(0)	and man	or se etat	od.	
	e Hos 124 hi e Fun letely	ledi	(Check 2	Medical Exam	iner: On the basis	of examination	on and/or invest	tigation, i	n my opinio	n, death oc	curred at	the time, date	and plac	e, and du	e to the ca	use(s) and r	manner stated.
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	6		30. Name and addr	ess of person who		,								-t			
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	Sta Registra	re.	31. Date filed (Mont	P 0 4 2012	Reg	gistrar's Signa	ature	12.1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Beach Tinker September 01, 2012 10:10A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore County Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months Hours 213-34-0029 1 🗆 M 2 🖰 F Nov. 10, 1936 Director 75 Winchester, VA. 28a-f show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA. York County Delta 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 157 High Ridge Road 17314 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iter 14. Race - American Indian Armed Forces Black White, etc. þ 1 Never Married 2 Married Yes 1 Yes 2 No Specify White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CFCX BRR Second Grade School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Theophilus French Olive Mabel Adams 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 **High Ridge Road Delta, PA. 17314** Ms.Linda M. Prouty (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Thursday 20c (Baltimore County) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dularey Valley Meliocial Timonium, Maryland 4 Donation 5 Other (Specify) Sept.06,2012 21. Signature of Funeral Service Licens Jeffrey L. Cair, Sr. OFSP 22 Name artificial Professional Attended Timenium, Maryland 21093-2215 Rart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknow: 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this c_rtifi_ate 2 🗆 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? or Attending Physic 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural Accident 5 Pending injury 1 Yes 2 No Investigation within 24 hours after deatl To the Funeral Director:, completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition or To this basis of examination and country opening at the land place and place 29b. Signature a 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:30 PM 30 30 Helen Earline Trainor 2012 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 461-22-5807 Director 1 □ M 2 🛛 F 23,1925 87 Yrs Vincent, Jan. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Parkville Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 0088 Walther Blvd. Apt. 1113 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married filed within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Madison Savings Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) S. D. Sullivan Lucy Bell Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 46 Shaftsbury Court Reisterstown, MD 21136 Donald Trainor- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept^{Date}mber cemetery, crematory or other place)
Evans Funeral
Chapel - Bel Air 1 Burial 2 Cremation 3 Removal from State Forest Hill, 4 Donation 5 Other (Specify) 1, 2012 ²² Name and Address of Facility Evans Funeral Chapel & 8800 Harford Rd. Parkv 21. Si mature of Funeral Service Licensee Cremation Services Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ HOWIC POSTRUCTIVE PULMON Medical sulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): use as the burial-transit the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FÉMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for it in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 🗌 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 2 🗌 No 1 Tyes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and e of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06501 State of Maryland / Department of Health and Mental Hygiene Forrest Taylor 2012 28030 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 29, 2012 0410 hrs **Medical Examiner** Taylor Forrest 4b. City. Town or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Raltimore Good Samaritan Hospital Baltimore City 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number **Funeral** oreign Months Days Hours Director Country) Maryland 219-80-4677 1X M 2 F 44 03/29/1968 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Glen Burnie permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 United States 8 Harvard Road Funeral 14. Race - American Indian, 8lack, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces' 1 Never Married 2 X Married Yes 2X No African 1 Yes 2 X No specify: If Yes, Give Year Specify: American ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Police Officer Police Department 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Darlene Warnick Clarence Taylor, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Glen Burnie, MD 21060 Mrs. Ambre L. Taylor / Wife Harvard Road 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 09/05/2012 | Glen Burnie, MD Atlantic Crematory Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Fuperal Sa Singleton Funeral & Cremation MO1121 Services PA: 2nd Ave SW; Glen Burnie, MD 21061 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and failure. List only one cause on each line /Medical Death a Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Deep Venous Thromboses Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit requires that the death certificate be executed Physician/Medical AMENDED g physician a UNPENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Þ 1 Yes 2 No 3 Probably 4 V Unknown status post motor vehicle collision, lumbar degenerative disc disease, obesity σ. Completed Records, Were autopsy findings available 24a. Was an autopsy pnor to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 🗸 Inpatient Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Certification: Subject driver of auto in collision Feb 18, 2012 0540 hrs Natural 1 ✓ Yes 2 No Pending Investigation 2 🗸 Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 600 Guilford Avenue, Baltimore, MD determined (Specify) Local Street To the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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State Registrar

ORIGINAL

Louise 30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD 31. Date filed (Month, Day, Year,

DOME

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

August 30, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar 28031 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 29,2012 Physician/ BILLY RALPH VEST, SR. AUGUST 1:00 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3833 E. JOPPA ROAD APT.A2 NOTTINGHAM 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign Days Months Hours Director 230-42-7997 1**▼** M 2 □ F 76 12-28-1935 VIRGINIA Yrs. 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD BALTO. NOTTINGHAM 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3833 E. JOPPA ROAD APT.A2 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates. 1954-1956 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry BALTIMORE CITY (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) CENTRAL DISTRICT 8TH POLICE OFFICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KEITH VEST VIRGINIA BLACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i <u>MICHAEL F. VEST</u> SON 4006 SILVER SPRING ROAD APT.B2 NOTTINGHAM, MD.21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 9-1-2012 GARDENS OF FAITH BALTIMORE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the dishock, or hear 1.00 se of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause we each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ TASTATIC eNOCARCINOM. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year been signed by the a should be detached 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 performed After this certificate Yes 2 No 1 🗌 Yes funeral director. 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes **3∕** No Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at I or Attending F after death. 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 8 3/ 12 nucl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERBAC Philoselphia 110 MICHAE

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State Registrar

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amend 19a, 20b, per fh, g931 9-7-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARYJANE Physician/ 2012 10 WILKERSON AUSUST Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE GOOD SAMARITAN BALTIMOLE CIT Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Oct. 13, 1938 Months Hours Maryland 151-30-6348 **Director** 1 🗆 M 2 🔀 F 73 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10a. State 10c. City. Town or Location Director Baltimore MDN/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 3720 Springwood Avenue Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene. 27 Is marked other than traumatic event, the Me Own Home Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Preston Dorothy Evans 19a. Informant's Name/Relationship (Type, Print)

Joy Silver
Joy Sliver daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9450 Ridgeview Drive-Columbia, Maryland 21046 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lbk cemetery, crematory, or other place)
Arlington National
Cemetery 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia 4 Donation 5 Other (Specify) 9/27/12 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel and Cre
8800 Harford Road-Parkville

23a. Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATOLY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** NEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE PULMONARY Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed LUNG CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed Yes 2 ATRIM FIBRILLATION this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural iniury 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BIND BALTIMORE, MB 2 1239 HERBERT 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month Jesse Lee Wendt Sr. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 810 Briarhill Place Apt C Essex Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 218-44-9742 1 □ M 2 □ F 65 Usual Residence of Decede 11-2-1946 MD 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28e-f sl the Medical Examiner must be notified 1 Yes 2 No Baltimore **Essex** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 810 Briarhill Place Apt C filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White 68 - 70Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) GM Assembler Automotive Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Lee J. Wendt Dorothy Overman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Wendt Wife 64 Talister Court Rosedale MD 21237 Department of Heal Important: If item 2 eny injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9-2-2012 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P. 7110 Sollers Point Road Dundalk, MD M01176 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardio vascular enusc 210 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see or injury Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably Winknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 🗌 Yes 2 🗌 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ,201^{ea} 12:27a [™] August James Donald Waltman, Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Ctr Bel Air Co. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min Days Director 213-36-6841 1 🛛 M 2 🗆 F 74 9-19-1937 Maryland Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 271s marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 X No MD Harford Co. Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 1402 Q Joppa Forest Drive 21085 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 K Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Printing Pressman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Sadie Mooney Frank J. Waltman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 1402 Q Joppa Forest Dr. Joppa, MD 21085 Patsy L. Waltman/Wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 9-6-2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Incensee MO1259 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimire, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 060 disease or condition Medical resulting in death) Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and resulting in death) Last Due to (or as a consequence of): attending physiclan Physician/Medical page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, To Be Yes_ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Division of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 200 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chosapeako Dr., Bel Air MW 21614 ueto Sc. ermir Duce

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State Registrar

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32. Registrar's Signature

Nonth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28035 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2:20 A M 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MORE THOMAS Prince Georges Hyattsville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 1 🕱 M 2 🗆 F 578-42-5828 78 22, 1933 DC show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Upper Marlboro Prince Georges 10e. Street and Number 10g. Citizen of What Country? Funeral 20774 13007 Cannon P1. USA filed within 72 hours after death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes
If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify "natural", 3 Widowed 4 Divorced Specify: Completed Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Facilities Manager Federal Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Mary Lyle Clarence Edward Watson, Sr. and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Upper Marlboro, MD 20774 Page 1 and 2 13007 Cannon P1. Yvonne Watson - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 9-4-2012 Brentwood, Md 21. Signature of Juneral Service Licensee MarsharideMarchillFuneral Home of Maryland scloreno 4308 Suitland Rd. Suitland, Md 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PROSTATE CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner LON Sequentially list conditions, frany, leading to immedicause. Enter Underlying Cause (Disease or injury that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as the t ttending IF FEMALE: 9SD 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an e Hospital or Attending Physician; The law 124 hours after death.

Funeral Director; After this certificate has to autopsy perform 2/ No 1 Yes Yes. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No injury Natural 5 Pending Investigation Acciden
□ Suicide Accident 6 Could not be

Division of Vital Records, P.O.

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

29a. Certifier

(Check

only one)

LASALUS ROAD

determined

MYATTS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REGENT M CAKE! L

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 08/30/2012

within 2 To the 6

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8015FQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29° 2012 Young Ja Yi August 9:33 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 2600 Orleans Street ocial Security Numbe 7. Age (In vrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min Dec. 15, 1940 212-98-9363 72 1 🗌 M 2 🔀 F Tonghwa, China **Director** Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21224 items 23a 2600 Orleans Street within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Korean 3 Divorced If Yes, Give "natural", Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) **05** College (1-4 or 5+) Hair Styling Beautician event, Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other transpine. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Young Chi Kwon Ki Se Yi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Maryland 21236 8663 Ridgelys Choice Dr. Mr. Jonathan C.Yi (Brother) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of (Harford County) Saturday Evans Fureral Chapel and Sept.01,2012 Forest Hill, Maryland (USA) 4 ☐ Donation 5 ☐ Other (Specify) Cremetion Services, Inc. Signature of Funeral Segrice Licenses Jeffrey L.Gair, Sr. OFS 2 Proceeding Allicenses Funeral and Cremation Center, P.A.

Allin, A. Lic. 1400677 2325 York Road Timonium, Maryland 21093-2215 Rart 1. Enter the disease shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tonly one cause on each line. Opset and Death Immediate Cause (Final Ph_sician/ ard. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the use as 1 ate has been signed by the attending page 2 should be detached for use as IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes No completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 102 Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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To the I within 2 To the I

31. Date filed (Month, Day, Year) State Registrar

(Check

only one)

2 L. 3 L.

SEP 0 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65

32. Registrar's Sigrature

29b. Signature and title of certifier

ORIGINAL

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

An (LBI RM

8/29/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 30 AUGUST 2012 ZEITZOFF 06:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours Min. Country) Director 215-03-2487 1 □ M 2 🏻 F 95 02/22/1917 MD Usual Residence of Deceden of Merical Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 💹 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4730 ATRIUM COURT, 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married filed within 72 hours after δ 1 ☐ Yes If Yes, Give 2 🕅 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be CHARLES SPERLING FREDA GOLDSTEIN permit. Page 1 and 2 should Department of Health and IV Important: If item 27 is ma any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN ZEITZOFF/DAUGHTER TYLER FALLS COURT, #F, BALTIMORE, MD 21209 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 08/31/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Liver 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) cance Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physiclan for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown the be detached g Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Section (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide injury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

State Registrar

within 24 hou

To the Fune

completely fi

29a. Certifier

(Check

only one 29b. Signaty

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

towow mo

30 2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} 2012 Manmohini Arora August 4:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Silver Spring Prince George's If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months (Month, Day, Year) **Director** 324-44-1512 1 M 2 X F $84^{\text{Yrs.}}$ Usual Residence of Dece July 1 India ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland | Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Funeral 3154 Gracefield Road Apt. HGT03 20904 United States ral", or items ? Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc. 1 Never Married 2 X Married δ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. er than "natural", the Medical Exa If Yes, Give leted 3 Widowed 4 Divorced Year or Dates Asian Indian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Compl (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ould be filed with nd Mental Hygien marked other ti 5+ D.C. Government Social Worker item 27 is marked other other traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ <u>Ram Narain Singh Sarin</u> Maharani Devi Sarin and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Ramona Manikarnika / Daughter 13017 Piney Glade Road Herndon, Virginia 20171 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arundel Crematory Odenton, Maryland Funeral Service Li P.A. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death months Ph sician/ **ASCVD** Medical resulting in death) Due to (or as a consequence of): Examiner 6 months Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Lines orderlying Examine Due to (or as a consequence of) and -trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death ed by the a detached f Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed be de 23e. Did tobacco use contribute to the cause of death? by been sig should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performe death? Hospital or Attending Physician: The 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending s after death 2 Accident 3 Suicide 2 🗌 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours af

To the Funeral D

completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Numbe Prantitioner: To the best of my knowledge. Seath occurred at the time date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10 (10

State Registrar

DHMH 17 Rev 06-2011

NP 3110 Gracefield Road Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registry's Sig

dine Harding,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** WILLIAM WYATT ANDREWS 2012 3:50P [™] 30 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore County Genesis - Franklin Woods If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 VA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days X□M 2□F 96 226-03-0834 26,1915 Director Oct. Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore County 1 Yes 2 No Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 103 Riverthorn Rd. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1XXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X2X No Specify White Specify þ WW 11 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) llth grade Steel Industry Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Eldridge Andrews Margaret Mattox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Wyatt W. Andrews (Son) 307 Bowleys Quarters Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State Date 20a, Method of Disposition XXBurial 2 Cremation 3 Removal from State 9-5-2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Lassahn Funeral Home Baltimore, Md. 21236 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 83 Tasseln 7401 Belair Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Severe - end stage disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last attending physicien for use as the buria Completed by Physician/Medical as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Hypthyroidin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ŧ P 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural nours after death. Ineral Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0073841 08/31/2012 MŊ 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 8213 walthon Woods Ra, Svit+204. Parkville, MD Shushil Sagar, ND egistrar's Signature 31. Date filed (Month, Day, Year) 32.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 2 , 20%2 Physician/ 0510 Linda Mae Aitken Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Valley Nursing Rockville & Wellness 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Jun 30, 274-34-3036 1939 Ohio **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d, Inside City Limits 10c. City, Town or Location at 10a. State Director Examiner must be notified 1 ☐ Yes 2 X No MD Bethesda Montgomery 5 10e, Street and Number 10f. Zip Code 10g. C Citizen of What Country? 20816 Funeral 4107 Maryland Avenue or items 23a within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates. Specify: White "natural", Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeping Owner permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jenny Mae Walther Edwin Barner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 Maryland Ave. Bethesda, MD 20816 Steven David Aitken/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/06/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) year Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Unidentiting Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Year Month Day Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ER/Outpatient 3 DOA ၉ 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 5 Pending Investigation the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State)

OV

State

Registrar

Medical

29a. Certifier

only one) 29b. Signatu

e and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Donald Whiteford Antos 2:56 PM EPTEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GREATER BALTIMORE MEDICAL
5. Social Security Number 6. Sex 7. Age (in ye) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days 213-30-5998 1 X M 2 □ F **Director** 1933 20, Maryland Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏹 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Stags Head Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Vincent Antos Mary Pauline Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / wife 900 Stags Head Road; Towson, MD 21286 Rosalie E. Antos Baltimore, 20a. Method of Disposition

1^A Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Dulanev Vallev Mem Gardensi 9/7/2012 5 Other (Specify) Timonium, MD 4 Donation Signature of Fund al Kervic 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician/ Neele Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury vears Due to (or as a consequence of): Exami eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled n by the fu Investigation ☐ Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 535 N. ousn harles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

N tos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 29 Larry Ronald Brasher 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death GLEN BALTIMORE PATER ANNE DARHINGTON MEDICAL Social Security Number 8. Date of Birth (Month, Day, Dec. 17 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 226-50-8491 Director 1 X M 2 □ F 74 Usual Residence of Deceder 28e-f show with the Merylend 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Worchester Ocean City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23e 3 Dorchester Street 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, \$ 1 Never Married 2 Married "neturel", or 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-003 1 ☐ Yes 2 ☐ No Specify. White 3 Divorced 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F t. Pege 1 end 2 should be fill tment of Heelth and Mental tant: If Item 27 Is merked o Chester Wheeler Brasher Hammond Pauline 19a. Informant's Name/Relationship (Type, Print) 24STE19 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Rothermel (daughter) 3 Dorchester Street, Ocean City, MD 21842 Date 31 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 e
Depertment of H
Important: If Ite
any injury or ott Metro Crematory or other place) 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Baltimore, MAryland 4 Donation 5 Other (Specify) Signature of Funeral Service Li 22. Name and Address of Facility one and Address of Facility
Stallings Funeral Home,
3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ JEUMON1/t disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner - HEART MISEACE HPTHE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): of or attending Physicien: The lew requires thet the deeth certificate be executed efter death.

Director: After this certificate hes been signed by the attending physicien end ed by the attending physicien end deteched for use es the burlei-trensif Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No a ☐ Unknown sete hes been signed by page 2 should be detec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No funerel director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident Investigation
6 Could not be the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State To the Hospital o within 24 hours of To the Funeral Di completely filled in Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cept MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)... 4A-BB HUC 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State SEP 0 5 201 Registrar

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	Physicia		Joan Buck	2017						Month August	29,	2	Year 012	3. Time of 8:00	a M
my	Medic Examir		4a. Facility Name (if not institution, give	ve street and numbe	r)		4b. City, Town, o	or Location of		iagase		ounty o		0.00	a
			Cherry Lane Nur	sing Cent	er		Laurel				Pri	nce	Geo	rge	
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	the hard	Ö	10e. Street and Number		1		10f. Zip Code				10g. Citize	n of Wh	nat Count	ry?	
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21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ted by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? XX No		Vas Decedent of H f Yes, specify Cub ☐ Yes 2★\(\frac{1}{2}\)	an, Mexicar	n, Puerto R	ify Yes or No- ican, etc.)		Black, ecify:	- America , White, e Afri Amer	can-	
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Maryland	2 should be file lith and Mental 27 is marked of traumatic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street			_	er, City or To	wn, Sta	ite, Zip C	ode)	
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Baltimore,	Je 1 a t of H if ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from Sta		lace of Dispo emetery, cren	sition (Name of natory or other pla			ate	20c. Loca	tion - C	City or Tov	vn, State	
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Bal	permit. Page 1 a Department of H Important: If ite any injury or ot once.	13	21. Signature of Funeral Service Lice	nsee	M0105		Name and Address Nala							∋, P.A	•
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687	ertific ding p	× ×	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of preana	ncv					00	J D-4-	of delive		
. Box 687	is that the death certificate be executed igned by the attending physician and be detached for use as the burial-transi	Physician/Me	in the past 12 mouths? 1 Yes 2 Who 9 Unknown	1 Live Birl 4 Pregnar 9 Unknow	th 2 🗀 Feta nt at time of c	ıl death 3 🗌	Ectopic pregnan Other (specify)	су		230	23	Mont		,	⁄ear
P.O.	that the ned by a deta	by P	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying cause gi	iven in Part	l.	23e. Did t	obacco use	contrib	ute to the	e cause of de	eath?
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Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	al Cert	4 Homicide determine	d 28e. Place of building,	etc. (Specify)	eet, factory, office			8f. Location (\$ City or Tov	vn, State)				er,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check 2 Medical Exar	ysician: To the best niner: On the basis o Irse Practitioner: To	of examination	n and/or invest	igation, in my opini	on, death or	ccurred at the	he time, date a	and place, ar	nd due t	o the cau	se(s) and mar	nner stated.
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_			30. Name and address of person who MANO HAR K.	completed cause of	f death (Item	23a) (Type, F	Print) 3_1111 1	2:000	p	1 -100	VA A	del	ph'	Mn .	7-700
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Bonner 1:27 PM OS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mary land Iniversity of Baltimore Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Months (Month, Day, Year) 218-54-4456 **Director** 1 🗆 M 2 🗓 F 64 May 16, 1948 Maryland 28a-f show 10a, State 10h County 10c, City, Town or Location must be notified at 10d. Inside City Limits Director Maryland Baltimore Reisterstown 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 702 Sungold Road 21136 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2X Married 2 ☐ Yes 2 X No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Conner Alberta Hillvard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health an: If item 27 is Charles Bonner (husband) 702 Sungold Road Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Page 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Carroll Cremation, Inc 8/31/2012 | Hampstead, Maryland Signal of Funeral ervice License 22. Name and Address of Facility ELINE FUNERAL HOME Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. List only one cause on each line. or heart ailure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Shock disease or condition resulting in death) Septic 2 weeks Medical Due to (or as a consequence of) Examiner Marrow Failure Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) AM burial-trar that initiated events or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the h as IF FEMALE: for use es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performe death? this certificate 1 Yes 2 No 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work 1 Tes 2 🗌 No Accident Suicide Investigation the within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08/29/2012 NPT: 1255607354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St, Baltimore, MD 21201 Cappelletti 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	Marylan		rtment of H tificate of L		and M	-	20	112	280	11.5
-			Registrar 1. Decedent's Name (First, Middle, La	ist)		Och	Theate of L	Jeann		2. Date of De	Reg. No. /	116	3. Time of I	
P	Physicia		Muriel Jane	Burke						Month Septem	Day	2012	2:45	AM
	Medic Examin		4a. Facility Name (if not institution, giv)		4b. City, Town, o	r Location o		Depeem		y of Death	2.13	
			8434 Bussenius R	load		j	Pasade	ena				e Aru	ndel	
	uneral		5. Social Security Number 6. S		Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th	9. Birthp	lace (State or	Foreign
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Via Id be	arked atic e	으	George Stil	ler				Dora	a E	lizabe	th Bo	blitz		
Maryland 2 should be filed	If or result and wenter in years, it for it fem 21 a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	178	19a. Informant's Name/Relationship (- 1	g Address (Street						ode)	
e, s and 2 Healt	em 27		Michael Ross Bur 20a. Method of Disposition	ke / Son	las: 5		Busseni	us Roa			-			
ge 1	0 - F		1 Burial 2 Cremation 3	Removal from Sta	te C	emetery, crem	sition (Name of atory or other plac			ate	20c. Location	,		
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			23a. Part 1. Enter the disease, or con	nplications that caus	ed the death							7027	Approximate	
- Ph	sicin/		shock, or heart failure. List only Immediate Cause (Final disease or condition			CF	TNEER	14/	1.	1114 8	M 5-	7.	Interval Betw Onset and D	eath //
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certific	ending use a	N/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnance	21/			23d. D	ate of delive	ry	
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e Hos	e Fun	Medical	(Check 2 L Medical Exan	niner: On the basis o rse Practioner: To the	f examination	n and/or investi	gation, in my opinie	on, death o	ccurred at t	he time, date a	and place, and di	ue to the cau	se(s) and man	ner stated.
To th	To th		29b. Signature and title of certifier			,	29c. Licens				29d. Date signe			
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			30. Name and address of person who	completed cause or		, , , , ,	,		Λ .	^		,	,	
	C.L.		Michael F. Gue 31. Date filed (Month, Day, Year)	thy MO	Strar's Signat	SI I-t	Smallo	pear	Red !	Jel F	, or 2 mg	Len	mg.	21122
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 2 Year Louis Marion Bykoski 31 August Medical 1820 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Country 287-22-6696 Director 1 🖾 M 2 🗆 F Feb 7, 1928 permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Germantown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18562 Eagles Roost Drive 20874 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 ☐ No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates.1946-48 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Economist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley Bykowski Theresa Sladewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 18562 Eagles Roost Drive Germantown, MD 20874 Janet Davis Bykoski/wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 09/05/2012 Woodbine, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ertora Duodenal disease or condition resulting in death) Medical Due to (or as a consequence of): Examine vod Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificete be executed 124 hours after death. • Funeral Director: After this certificate has been signed by the attending physician anu letely filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? ٥ 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville. 99.01 State Registrar

2012

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BVK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 29d, per phy, g931 9-5-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Paul Thomas Beck, Sr 2012 Aug. 1800 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Shady Grove Adventist Hospital</u> Rockville Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Director 579-40-0759 1 🛣 M 2 🗆 F 80 Mar. 3,1932 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Funeral Director 28a-f Montgomery Rockville 1 X Yes 2 □ No MD 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 9701 Medical Center Drive 20850 USA death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. Examiner 0 þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced Specify: Caucasian r Yes, Give Year or Dates 1952-56 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Banking Messenger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emma Joanne Simonte Louis Beck and (19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Betty Jean Beck / wife 600 12th Ave. Apt. 18 Aynor, SC 29511 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/30/12 Woodbine, MD 21. Signature of Juneral Service Licensee Going Home Cremation Servcie P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death arrhy Physician/ malignent disease or condition resulting in death) Medical Due to (or as a donsequence of) **Examiner** hours hunckia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to () a a consequence of): Exami distress hours respiraton Cause (Disease or injury tranand that initiated events resulting in death) Last physician a s the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year Yes 1 Yes 2 L 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy perform 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 KNO 1 Yes ည 1 Inpatient 2 TER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completely filled in by the Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Numa Practificment of the control of the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month), 8/24/2012 D0068025 6+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockville, momland 9901 Jonathan wenky MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 5 2012

Registrar

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7412017

August

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September D Daniel Edward Boyle, 2012 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville 206 Hardy Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In vrs. last birthday Days Mar 27, Director 184-20-8862 1 🔀 M 2 🗆 F 84 Pennsylvania 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20852 206 Hardy Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates. WWII 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Loretta Slattery Daniel Edward Boyle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 13232 Foresman Blvd. Port Charlotte, FL 33981 Kathleen Boyle/daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 09/07/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22 Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 20129 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Infarction disease or condition resulting in death) Acute Myocardial davs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) a Linknown Records, P.O. ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 K No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pagi 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 📐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one)

10+1

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D34032

29d. Date signed (Month, Day, Year)

September 4, 2012

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 1 Physician/ John Edward Bresch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6, Sex 1 X M 2 □ F **Funeral** 8. Date of Birth (Month, Day, Yea Davs Hours 72 Director 169-32-5067 1940 Jsual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location Director MD Montgomery Montgomery Village 10g, Citizen of What Country? USA 10e. Street and Numbe 20120 Darlington Drive 20886 tems 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter þ 1 Never Married 2 X Married filed within 72 hours after al Hygiene. 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates. Vietnam Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Lobbyist Non profit is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ Agnes D. McKees John H. Bresch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey John Bresch/son 1008 Beaver Road Sewickley, PA 15143 permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometer, crematory or other place)
Final Journey Crematory 09/07/12 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Coing Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of ailure. List only one cause on each line. Immediate Cause (Final Physician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to Immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 2 should 24a. Was an nas autopsy page performed? Yes 2 No certificate Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital funeral director Hospital: 1 ☐ Yes 2**X** No Other: 잍 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred XNatural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

28049

1530

10d. Inside City Limits

1 🗆 Yes 2 🔀 No

MD 21029

Year

Approximate Interval Between Onset and Death

9. Birthplace (State or Foreign Country)

Pennsylvania

2012

Black, White, etc.

Month

29d. Date signed (Month, Day, Year)

September 1, 2012

Day

Were autopsy findings available prior to completion of cause of

death?
1 Yes 2 No

To the l within 2 To the l

29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

31. Date filed (Month, Day, Year)

29c. License number

D60634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State	epartment of Health and N	lental Hy	giene	
		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea	Reg. No.	28050
Physicia Medi		Kenneth $_{ m R}.$	Brosious	Month Sept.	Day 2012	3. Time of Death 6:45 P M
Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	вере.	4c. County of Death	
noti:	М	7934 Wise Avenue	Dundalk		Baltim	ore Co.
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day		nplace (State or Foreign intry)
	1	219−20−6745	S.	Aug. 1	.6,1926 Pen	nsylvania
yland f sho	tor	10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits
e Mar r 28a notifii	Sire	MD Baltimore 10e. Street and Number	Dunda1k			1 Yes 2 No
rith th	Funeral Director	7934 Wise Ave.	10f. Zip Code	- 1	10g. Citizen of What Cou	<i>'</i>
eath w	nue	11. Marital Status 12. Was Decedent Ever in U.S.	21222 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	United Stat	
fter de amine	by	1 ☐ Never Married 2 🕅 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Completed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. WWII	1 Yes 2 X No Specify:		Specify:	White
715 h	mple	(Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of worki e. DO NOT use retired)	ng	16b. Kind of Business/I	
212 within giene. er tha		College (1-4 or 5+)	lechanic		Automobil Mechanic	е
land be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, I		
ryla uld be d Men marke	-	George E. Brosious		e G. Wa		
Baltimore, Maryland 21215-0036 Dermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myning or other traumatic event, the Medical Examiner must be notified at anone.	Į,	19a. Informant's Name/Relationship (Type, Print) 19b. M Ms. Patti A. Brosious (Daughter) 79	failing Address (Street and Number or Rura 134 Wise Ave. Dunda	Route Number,	; City or Town, State, Zip	
of Head of Hea		20a. Method of Disposition 20b. Place of D	isposition (Name of	ate	20c. Location - City or T	
Page Page ment ant: It		Donation 5 Other (Specify) Meadowr	crematory or other place) idge Mem. Park 9/7	/2012	Elkridge,	Marvland
Baltimore, I permit. Page 1 and 3 Department if the all Important if item 2 any injury or other	15	21. Signatur of Funeral Service Licenson 1 ennis Carroll	Duda-Ruck Funeral 7922 Wise Ave. Du	Home of	Dundalk, I	nc.
		20a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	respiratory arre	est,	Approximate Interval Between
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Medical Examiner		resulting in death) Due to (or as a consequence of):				
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760 cate be	edical	d				
certificate nding physuse as the	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			004 D-4 f-1-15	
Box death o he atter	Physician/Me	in the past 12 months? 1 ☐ Ves 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	Day Year
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40 = 0	d by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	_	bacco use contribute to t	
rds, requires been sign	lete				es 2 No 3 Pro	
Kecords, The law requires sate has been sig	Completed			24a. Was a autops perforr	sy prior to co	psy findings available empletion of cause of
al F		25. Was case referred to medical	26. Place of Death (Check	1 Yes	2 No 1 Yes	2 No
of Vital Physician: this certific ral director,	မ	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor		ence 6 Cther (Specify	1)
Ing Ph	ate:	27. Man of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injur	e of 28c. Injury at 2 Work?		w injury occurred	
VISION or Attendir fter death. irrector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Di Lantina (Di		10-11
al or / s after I Dire		4 Homicide determined determined building, etc. (Specify)	Street, lability, office	City or Town	reet and Number or Rura n, State)	Houte Number,
DIVISION OF VITAL RECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or imonly one) Certifying Nurse Practitioner: To the best of my knowled	vestigation, in my opinion, death occurred at t	he time date and	d place, and due to the ca	ueale) and manner stated
To the To the Vithin To the COMP		only one) Ortifying Nurse Practitioner: To the best of my knowled 29b. Signature and the of certifier	29c. License number	2	e cause(s) and manner as: 9d. Date signed (Month,	
		M. D.	0 33214		09/04/18	2
20X1		30. Nancend address of person who completed cause of death (Item 23a) (Typi	0 33214 0 9000 Fran	Klin (6 Ph Ba	110,17
Stat	е	31. Date filed (Month, Day, Year) SEP 0 5 2012 3. Registrar's Signature	arke		7,0	21231
Registra	r	SET U D ZUIZ JOHNAN JO. 19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For	State of Mary				Mental Hy	giene	
		State Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of I	Death	100.00	Reg. No. 20	2 28051
Physic	ian	Ha manet Raul	:60				2. Date of De Month	Day Ye	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Deat	h Deptent	4c. County of D	2 7. 27 eath
<i>'</i>		Johns Hopkins Bayvie			Baltimore				/A
Funeral Director		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ly, Year)	Birthplace (State or Foreign Country) [aryland
70		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or L			Whiti	2791724 1	
Maryla -f sho ed at	to	l logi obality		c. Oity, Town of L	ocalion		D . 1	11	10d. Inside City Limits 1 ☐ Yes 2X No
th the or 28a notifi	Director	10e. Street and Number	imore		10f. Zip-Code		Dund	10g. Citizen of What	Country?
ath will	ral	1722 Stokesley	Road			1222		United S	tates
ter de	Funeral	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No 	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
lours at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
"natul	letec	15. Decedent's Edu (Specify only highest grade		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busine	ss/Industry
Individual Caracteristics of the Manyland 2 should be filed within 72 hours after death with the Manyland 2 should be filed within 72 hours after death with the Manyland", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) 8 Years	College (1-4 or 5+)		<i>bonor use reure</i> c iemaker	1)		Own Hom	e
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y ra	မ	Joseph Haubner 19a. Informant's Name/Relationship (Typ.		10h Mail	ing Address (Chart		le Mante	L er, City or Town, State	
ine, intally ideal of IZIS-DUDGO. Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene is the state of the state of the state of the world is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mr. Dennis J. Bay	*					$oldsymbol{ iny}$ or lown, state $oldsymbol{ iny}$ Maryland	
es 1 a of Her fittem ir othe		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ Re	emoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
t. Pag rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify)		Hilltop	Service C	Corp 9/5			Maryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service License	1 13	. Reed 2	Duda-Ruck	Funeral	Home of	f Dundalk,	
		23a. i = 1. Enter the disease, or complice shock, or hear dilure. Lie only one	cations that caused the	death. Do not en	1922 Wise ter the mode of dyir	ng, such as cardia	c or respiratory a	Maryland rrest,	Approximate Interval Between
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that the death certifical that the attending pheed by the attending pheed for use as the second seco	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3[☐ Ectopic pregnanc	у		23d. Date of a	delivery Day Year
the decreted the control of the all	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5[Other (specify)			Wionth	Day 16ai
s that the ned by	by P	Part II. Other significant conditions com		_				obacco use contribute	e to the cause of death?
w requires that been signed be de	ted	CVA, Atrial Fibi	rillation,	, Alzhe	mer's D	iseasc	1 🗆 \	/es 2 ☐ No 3 ☐	Probably 4 🗌 Unknown
has be ge 2 sh	Completed	1					24a. Was a autop	an 24b. Were prior rmed? death	autopsy findings available to completion of cause of
	ပ္ပ	25. Was case referred to medical				26 Place of Dec	1 Yes	2 No 1 1 Y	
ysiclan: is certifica director,	P B	examiner?	ospital: 1 🕱 Inpatient	2 ER/Outpatier	nt 3 🗆 DOA Othe			lence 6 🗆 Other (S)	pecify)
Attending Physician: In death. ector: After this certification by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work	y at </th <th>r</th> <th>now injury occurred</th> <th></th>	r 	now injury occurred	
kttendi death ctor: A cy the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - /	At home, farm, str		Yes 2 No	28f. Location (5	Street and Number or	Rural Route Number
al or A	Certification:	4 Homicide determined	building, etc. (Sp	ecify)			City or Tow		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edical	29a. Certifier (check only one) 1 ★ Certifying Physi 2 Medical Examin	ician: To the best of my ler: On the basis of exar and manner stated.	knowledge, deat mination and/or in	occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
To the vithin To the comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	nth, Day, Year)
		famer MD			RESI	066		Septembe	51,2012
り		30. Name and address of person who con SuJAY PATHAK		(item 23a) (Type,	Print)	4940 E		•	nore, MD, 21224

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PLAGEMEN State of Maryland / Department of Health and Mental Hygiene
Amend #2/ per OCME G941 7/30/13 dk
Certificate of Death
Reg. No 2012 28052 Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Margaret A. Bremer Aug 2012 1330 M Medical 30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital 8. Date of Birth 0-1 timore Social Security Number If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Min. Days Hours Maryland 95 12/7/1916 220-05-2185 **Director** Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 x No Baltimore Dunda1k 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7723 Norbush Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify. White Completed 3 Widowed 4 ☐ Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Anna Brendel William Charles Metzger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7723 Norbush Ave., Dundalk, MD 21222 Dolores Peisinger (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 9/5/2012 Baltimore, MD Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home 21. Signature of Funeral Service Licensee 7922 Wise Ave., Dundalk MD 21222 Justin Jones per DVR Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ racture 6disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to min schate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a conceguence of: CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery signed by the atter in the past 12 months?

1 Yes 2 No Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dependent 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Hypertension 24b. Were autopsy findings available 24a. Was an certificate has prior to completion of cause of death? autopsy perform Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-14 မ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural work? 1 Yes 2 No 5 Pending injury subject fell 8/23/12 s after death 2 X Accident Investigation unk Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number City or Town, State) 2300 Dulaney Val Ro 4 Homicide determined nursing home Lutherville MD 21093 within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

HOS DITAL

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ John J. Bowman 2012 6:30 A M Aug. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore City 310 South Oldham Street 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 😾 M 2 🗆 F Months Davs Hours (Month, Day, Yea West Virginia 232-34-2448 1930 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director Baltimore City 1 XYes 2 No N/A MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 310 South Oldham Street United States 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status 1 Never Married 2X Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. ₩₩ ፲ ፲ ş 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 10 Years College (1-4 or 5+) General Motors Corp. Automobile Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary J. Asbury John H. Bowman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8711 School Road Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) John L. Bowman (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1X Burial 2 Cremation 3 Removal from State Middle River, MD Holly Hill Mem. Gdns. 8/31/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens ²DidaªRdck° Fufferal Home of Dundalk, Inc. 7922 Wise Ave, Dundalk, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a so sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Dement. 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 🗆 Yes 2 🗀 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 \square Pending Matural Investigation Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R125808 30. Name and address person who completed cause of death (Item 23a) (Type, Print) narles St *4105 State Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

6 Could not be

determined

Suicide 3 ☐ Suicide 4 ☐ Homicide

3

29a. Certifier

only one)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2:55 AM Theresa Marquerite Barrett September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Symphony Manor Baltimore 8. Date of Birth (Month, Day, Year) Oct 26, 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign 98 Director 1 DM 2 F 215-07-8822 Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 27 Is marked other then "neture!", or items 23e or 28e-f's treumetic event, the Medical Evanturer must be notified 1 Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 7903 Bon Air Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐No Specify: 3 ₩ Widowed 4 Divorced Completed White 15. Decedent's Education cify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 1 and 2 should be filed w if Health end Mental Hygie Item 27 Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) lend Mental H ည Hauenstein Marion Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Barrett /Daughter 7804 Tilmont Avenue Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ertment of hoortent: If Ite 1 🗆 Burial 2 🛣 Cremation 3 🗖 Removal from State Sep 4 Donation 5 Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory 21. Signature of Funeral Service Licensee M01442 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ fall WITH Femur disease or condition resulting in death) 2 months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day 1 ☐ Yes 2 E 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD 3 CAD (Dee 2 Venous hrombosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ronic obstructive Lung disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 3) Coronar performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending July 7 2012 UNIC 1 ☐ Yes 2 🔀 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1601 E BELVEDER ST, BALTIMORE MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one and title of certifie September 1 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST. HARON CHMZLES M 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 201 2:15 AM 31 Charles Francis Busnuk August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Jun 04, 1948 Country) Maryland 1.**X**M 2 □ F 64 Director 218-48-0853 ed other then "natural", or Items 23a or 28a-f show event, the Medical Evanniner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 630 S. Linwood Ave 21224 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) h end Mental Hygien 7 Is marked other t MD State Government Grant Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည þe permit. Page 1 and 2 should be Department of Health end Men Important: If item 27 Is marke any injury or other traumatic Frank Busnuk Dolores Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George D Harris /Domestic Partner 630 S. Linwood Ave. Baltimore, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town State cemetery, crematory or other place, Sep 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M0144 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician ymphoms disease or condition resulting in death) Medical Due to (or s a const uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami inding physicien end use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten For u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Year Pregnant at time of death been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t director, page 2 s autopsy 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical funeral director 船 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 6 1 Other (Specify) WOSP (4 this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ie Hospital or אני... iin 24 hours after death. ייים Funeral Director: After "ייים in by the fur Natural 5 \square Pending 1 🗌 Yes 2 🗆 No 2 Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier who completed cause of death (Item 23a) (Type, Print) 13V

Registrar DHMH 17 Rev 06-2011

State

400

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 0119AM Katie Bailey -ugust 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ST. BALTIMORE AGNES HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) 97 Director 217-01-3978 1 🗆 M 2 🛣 F 10 26 14 SC Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MM NA Albuquerque 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9434 Lexington Ave Apt D NW 87112 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 ☐ No Specify: Black Specify: Completed 3 XWidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Housewife Home na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be filed tment of Health and Mental Η tant: If item 27 is marked oti jury or other traumatic even Junius Lucas Mary Etta Jones 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Whitaker-Md 21244 Daughter Kettle Ct, Windsor Mill, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Arbutus Memorial \$/7/2012 Arbutus, Md anature of Funeral Service Licensee M 22 Name and Address of Facility 300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cossner Vascolor Atheresaerstiz chknown Medical Due to (or as a consequence of): Examiner Hyperhalemi Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consularience of Hospital or Attending Physician: The lew requires that the deeth certificete be executed Cicke Della C. the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 2 No 9 Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 After this certificate has 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No မ 1 Inpatient 2 DER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate; 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 02753 2012 29. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herzland Agnes Baltimore Hospital 31. Date filed (Month, Day, Year) 32. distrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 31 2012 ar 5:50 A M Dean Gilbert Bedsaul, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min Hours **Director** 213-36-7595 73 1**X** M 2 □ F Mar. 9, 1939 North Carolina er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 208 Schucks Road death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher Public School 12 and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Blanche Almeda Crouse Dean Gilbert Bedsaul Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Patricia A. Bedsaul / Wife 208 Schucks Road, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Baptist Cemi. 9-6-2012 |Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY DISEASE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy BEDSAUL in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) page 2 should be detached 1 ☐ res _ _ _ 9 ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2 🗌 No Yes 2 No 1 🗌 Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 70 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE within 24 hours after death.

To the Funeral Lirector: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely only one) 3 🐰 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

а.п.

5:50

AUGUST

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

CRNP

MORGAN

TRACIE L.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28058 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :15 PM 2012 SHIRLEY BARTZ 9 U1 G Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death **BALTIMORE** BALTIMORE FUTURE CARE NORTH POINT If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Months Hours 0976774921 Director 90 MD 220-05-8614 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Madical Fyaminas mark to a state of the state 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **BALTIMORE** MD **BALTIMORE** 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral USA 21219 2825 LODGE FARM ROAD, #117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHI TE 1 ☐ Yes 2 X No Specify: 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **SEARS JACOB** ZIMMERMAN IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE HUTCHINS/DAUGHTER 221 PARKWOOD ROAD, BALTIMORE, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BEANSHE VESHEAR CEM. 09/02/2012 Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE, MD Donation 5 Other (Specify) of Funeral Service Cens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Sir PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PNELIMENITIS disease or condition resulting in death) Medical Examiner rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cancer CONFRITIV 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ျှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? iniury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or inventigation is a manner of the cause of examiners and one of the cause of examination and/or inventigation is a manner of the cause of examiners. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) 2012

State Registrar 31. Date filed (Month, Day, Year)

SEP 05

ristias

30. Name and address of person who completed cause of death (trem 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Plea	se Type or State o						ılı Copies 1ental Hyg		egible	•
	-	State Registrar				Ce	rtificate d	of Death	1		Reg. No.	nI:	28059
Physicia Medic		1. Decedent's Name		Last)	BULM	ASH	-			2. Date of Dea Month	Day	Year	3. Time of Death
Examin		4a. Facility Name (if	not institution,	give street and nur			4b. City, Tow	vn, or Location	n of Death		4c. Co	unty of Dea	
		WEINBER						TIMORE			1	I/A	
Funeral Director		5. Social Security N 215-10-		6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 95	last birthday) Yrs.	Months D	Year If Undays Hours	er 24 Hrs. Min.	8. Date of Birt Month Day 08/22			thplace (State or Foreign ountry) MD
t ow	_	Usual Residence of 10a. State	Decedent 10b. County		100.0	City, Town or Lo	ncation						10d. Inside City Limits
arylar a-f st fied a	Scto	MD	N/A	۸	100.0	BALT							1 Ty Yes 2 No
or 28	ä	10e. Street and Nur		-1		DALI	10f. Zip Co	ode			10g. Citizen	of What C	112
with t	Funeral Director	5883 PA	ARK HETO	GHTS AVEN	IIIF.			21215				US	3.4
leath items er mi	ᇤ	11. Marital Status			edent Ever in U		Was Decedent	of Hispanic C		cify Yes or No-		Race - Ame	erican Indian,
", or	þ	1 Never Marr			2 XNo		1 Yes 2			riloari, etc.,		Black, Whit ec <i>ify:</i>	e, etc.
2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	eted	3 🔀 Widowed	4 ☐ Divorced	Year or D									WHITE
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within giene. er tha the I	ပြ	Elementary/Sec	onday (0-12)	College (1	-4 or 5+)		OMEMAKE:	,			OV	N HON	ſΕ
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, La	ist)		•		18. Mo	ther's Name	e (First, Middle,	Maiden Surr	ame)	
ld be Ments arked atic e	욘	LOUIS			GO:	LDSTEIL	N	I	DA				PLATT
1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical		19a. Informant's Na								l Route Number		ın, State, Zi	p Code)
and 2 Health		PATSY N		DAUGHTER	001				_	TIMORE,		21209	T 0::
		1 X Burial 2	☐ Cremation	3 Removal from	State	cemetery, cre	osition (Name o matory or other	r <i>pl</i> ace)		Date		-	Town, State
			5 Other (Sp	-			I TFILO: 2. Name and A			2/2012			RE, MD
permit. Departr Importa any inju		MIN	will	Killere	1 -					L LEVIN ROAD, P			
- A		23a. Part 1. Enter t shock, or hea		complications that ally one cause on ea	caused the dea								Approximate Interval Between Onset and Death
Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a	(or as a conse	CIC							Offiset and Death
Examiner				Due to	_	0 6 1 7 1	C						
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cuted nd ransit	Examiner	cause. Enter Under Cause (Disease or that initiated events	iinjury	c			INAHO	64710	CFC	SKEMI.	4		
	cal E	resulting in death)	Last	Due to	(or as a conse	quence of):							
ate be physic the b	gig			d									
ertific Iding I se as	Physician/Medi	IF FEMALE: 23b. Was decedent	prognet	23c. If yes, ou	tcome of pregr	nancy					224	. Date of de	divon
atten for u	iciar	in the past 12 in 1 Yes 2	months?	4 🔲 Preg	nant at time of		Ectopic preg Other (specif				230	Month	Day Year
the de	hys	9 Unknown		9 Unk	nown								
s that gned l	by F	Part II. Other signif	ficant condition	s contributing to c	leath but not re	esulting in the	underlying caus	se given in Pa	rt I.	23e. Did to			the cause of death?
quire:	Completed									1 🗆 ነ	Yes 2	¶0 3 ∐ F	Probably 4 Unknown
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The cate h	ပ္ပ									perfo	rmed? 2 No	death?	s 2 🗆 No
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ath. :: After	Certificate:	1 Natural 2 Accident	5 Pending	(Mon	th, Day, Year)	injury		work? 1 Yes 2		Edd. Describe III	ow injury ou	ourrou	
Atter	ertif	3 ☐ Suicide 4 ☐ Homicide	6 Could n	ot be 28e. Place			reet, factory, of	fice				mber or Ru	ral Route Number,
tal or ins after al Dir led in			10	build	ng, etc. (Speci	19)				City or Tow	n, State)		
Hosp 24 hou Funer ted fil	Medical	(Check 2	Medical Ex		sis of examinati	on and/or inves	stigation, in my o	opinion, death	occurred at	the time, date as	nd place, and	d due to the	cause(s) and manner stated.
To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I	ž	only one) 3 29b. Signature and		Nurse Practioner:	To the best of r	ny knowledge,		at the time, da			e cause(s) and 29d. Date si		
FSFő		> 7	10 1	101/									*)
		30. Name and ada	ess of person w	ho completed caus	se of death (Ite	m 23a) (Type,	Print)		/ * `		-//	100/	
Ψ		/>	1.57	noples	CCA	essev	1'	2700	20	4184	c411	ō D.	1.21209
State		31. Date filed (Mont.	h, Day, Year) SEP 0 5	2012 32.5	gistrar's Sign	ature	backer						
Registra	•		SET U	CUIL A	The same of the sa	1. 11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1250/ Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death tho If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month. Day Director I.VAN Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No 10Re 10e. Street and Number 10g. Citizen of What Country? Funeral U.S 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1953 1 Yes 2 No Specify: 3 ₩idowed 4 ☐ Divorced Specify: WhiTe 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) CROWN, CORKANG conday (0-12) College (1-4 or 5+) peetar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of ☐ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic . Part 1. Enter the disease, or complication shock, or heart failure. List only one cause s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or imjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other 2 1 ျှ 1 🗌 Yeş 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural (Month, Day, Year) injury 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2024

		1 - For State Registrar 1. Decedent's Name (First, Middle)		f Marylar	-	rtificate				_	Reg. No. 2	012	280
Physici /Medio Examir	cal		LOUNT	nber)		4b. City,	Town, or	Location o	of Death	Month AUGUST	Day Z9	Year ZO12 5 y of Death	5: 68 P
		Johns Hopkins Ba	-			Baltir				,			
Funeral Director		5. Social Security Number 220–18–6922 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 07/24	th ay, Year) 4/1926	Country)	e (State or Forei
show		10a. State 10b. Count	у	10c. Ci	ity, Town or Lo	ocation						10d.	. Inside City Lim
Ba-f s	Director	MD BALT	IMORE	S	PARROW	S POI	NT						1 X Yes 2 □ I
a or 2 be no		10e. Street and Number 2522 SYCAMOR	77			10f. Zip	-Code 2121	9			10g. Citizen of	What Country?	?
Hygiene. other than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 XWidowed 4 Divorce	12. Was Dece Armed Fo rried 1 \(\subseteq \text{ Yes} \)	2 X No			lent of Hi ify Cuba	spanic Ori	gin? (Spe), Puerto	ecify Yes or No Rican, etc.)		ce - American ack, White, etc.	
"natu edical	Completed b	15. Decede	ent's Education est grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done c	luring mos	t of work	ing		Business/Indus	
Hygiene. other thar ent, the M	S	8			D	IETIC	LAN						OSPITAL
and Mental Hy s marked oth	To Be (17. Father's Name (First, Middle) WILLIS REED	, Last)							e (First, Middle MAE REI	e, Maiden Surna ED	ime)	
s marl	F	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mail	ng Address	S (Street	and Numb	er or Run	al Route Numb	per, City or Towr	n, State, Zip Co	ode)
f Health and N Item 27 Is ma other traumat		LORETTA GALBRE	ATH/DAUGHT						., S	PARROWS	5 PT., N	D 2121	9
Department of He Important: If Iten any Injury or oth once.		20a. Method of Disposition 1		State 20b.	Place of Disp cemetery, cre ST . STA	NISLA	US		09/0	1	BALTIMO		
peparti nporti ny Inj nce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F. 1701 LAURENS ST., BALTIMORE, MD 21217 23a. **rart 1. Enter the disease, or com, licutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interpretations into the control of the control											
0 2 2 0													
ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	STRO (or as a consec	quence of):							O	nset and Death
aminer	er	Sequentially list conditions,	b	(or as a consec	Thence of.								
ınsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	(01 40 4 0011000	4401100 017.		-						
ysician and ne burial-transit	cal	that initiated events resulting in death) Last	Due to	(or as a consec	quence of):								
r death. ector: A tter this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ☐ Fet nant at time of o	al death 3	_ Ectopic p _ Other (sp		,				ate of delivery onth Da	
signed by	by	Part ii. Other significant condit	ions contributing to d	eath but not re	sulting in the	underlying	cause giv	en in Part	I.	23e. Did	tobacco use co		cause of death
ate has been sig page 2 should t	Completed									24a. Was auto perfo 1 Yes		. Were autopsy prior to comp death? 1 \(\text{Yes} \) 2[y findings availabletion of cause
certificate irector, pa	Be	25. Was case referred to medica examiner?	11 11				Oth			(Check only o			
this o	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	·	ER/Outpatie		Othe 18c. Injury	4 🗆 110			dence 6 0		
within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	1 Natural 5 Pendi	ing (Mont	th, Day Year)	Injury	м	Work 1 □ `	? Yes 2 🗌	No				
rs after o al Direct led in by	Certif	4 Homicide determ	mined buildi	of injury - At h ng, etc. <i>(Speci</i>	fy)					City or Tov	. ,		
e Funer e Funer detely fil	Medical	29a. Certifier 1 Certify (check only one) 1 Medica	ing Physician: To the ii Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or it	h occurred nvestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	e cause(s) and r , date and place	manner as state e, and due to ti	ed. he cause(s)
withis To th comp	Me	29b. Signature and title of certification	er D				License	number			29d. Date sign		
		30. Name and address of perso		se of death (ite	em 23a) (Type				940 E		venue, B		
Sta	ite	31. Date filed (Month, Day, Year)		e strar's Signa	ature	barre	,						
Registr	_												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ricky Carter 01:24 AM Medical 09 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Somoviton nos Ballimore US A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month Day, Year 10-18-58 Director 213-70-0459 1 🖾 M 2 🗆 F 53 Yrs. MD Usual Residence of Decedent nit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland arment of Heathh and Mertal Hygiene. ordant: If tiem 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 1373 Walker Avenue USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. African 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify: American Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ΝÀ Home Improvement Company GED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lawrence Carter Wiggins Greta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21239 Regina Carter-Wife 1373 Walker Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Pege 1
Department of H
Important: If ite
any injury or of ¹XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 09-01-12 Randallstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, Maryland 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metartake disease or condition resulting in death) Medical Due to (or as a consequence of): years Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 24 hours after death. • Funeral Director: After this certificate has been signed by the a letely filled in by the funeral director, page 2 should be detached ' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 **☑** No Other: 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Suldi 09/01/12 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar hospitel

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32. Registrar's Signature

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31. Date filed (Month, Day, Year) SEP 0 5 2012

, Lock Roven Blud, Beltmore 21229.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		State of N	Marylan		artment of F tificate of E		id Me	ental Hy	giene Reg. No	20	12	28	063
Physicia	n/	1. Decedent's Name		st)			·-·		- [:	2. Date of De			Year	3. Time of	Death
Medic		PeggySu								Month 08	2	8	2012	1702	M
Examin	er	4a. Facility Name (if University	10FMary	and medic	alle	nter	4b. City, Town, or Baltimo	re			4c	. County o	f Death		
Funeral Director		5. Social Security N			Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8 Vin.	3. Date of Bir (Month, Da			9. Birthpl Countr	ace (State o	r Foreign
		212-82-98 Usual Residence		□ M 2 🕱 F		50 Yrs.				08/06,	/196	2	Mar	yland	
/land f show d at	tor	10a. State	10b. County		10c. City	y, Town or Lo	cation						10	d. Inside Ci	
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hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at	Funeral Director	10 Westo	ver Place	12. Was Deceden	t Ever in U.S	S. 13. V	21901 Was Decedent of Hi f Yes, specify Cuba		? (Speci	fy Yes or No-		S.A.	- America	n Indian.	
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filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	, Maiden	Surname)	Un	known	
uld be I Meni narke	2	Henry	Sizemo			1									
d 2 should be filed within 72 hours at 12 should be filed within 72 hours at 7 is marked other than "natura raumatic event, the Medical E.		19a. Informant's Na				1	ng Address (Street a estover P							ode)	
, E & E &		Edward Co		nusballu	20b. P	lace of Dispo	sition (Name of	1	Da			ocation - C		n, State	
permit. Page 1 a Department of H Important: If ite any injury or ot			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from Sta	i.e		natory or other plac Ets Registr		/31/	/2012	 Han	over	. Mar	vland	
ermit. epartn nports ny inju		21. Signature of Ful	neral Service Liceo	see	117.0	22	. Name and Addres	ss of Facility	Ana	atomy	Gift	s Rec	gistr	У	
7 2 E 8 9	Ц		- A1	11	*		522 Conne					lanove	er, M	ID 210	76
			rt failure. List only o	plications that caus one cause on each l				g, such as car	diac or I	respiratory ar	rrest,			Approximat Interval Bet Onset and I	ween
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n certi iendin ir use	an/N	IF FEMALE: 23b. Was decedent in the past 12-		23c. If yes, outcom			Ectopic pregnanc	ev.			- 1	23d. Date			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	1 Yes 2	No	4 Pregnan 9 Unknow	t at time of c		Other (specify)	·				Mont	th I	Day \	/ear
at the		Part II. Other signif		ontributing to death	but not res	ulting in the u	ınderlying cause giv	en in Part I.		23e. Did t	tobacco	use contrib	oute to the	cause of d	eath?
uires t n sign	ed by									1 🗆	Yes 2	□ No 3	B 🗆 Prob	ably 4X	Unknown
w requests been 2 shou	Completed									24a. Was		24b. W	ere autop	sy findings a	available
The la ate ha page	Com									auto perfo	ormed?	de	eath?		ause of
ician: sertific ector,	Be	25. Was case referre examiner?	/	Hospital:			V 041-	ace of Death (Check o	only one)					
Physic rthis ceral direction	. To	1 Yes 2	No h	1 Inpa		ER/Outpatier	nt 3 🖾 DOA	4 L Nursir		e 5 🗌 Resi					
nding ath. After	icate	1 Natural 2 Accident	5 Pending Investigatio	(Month, E	Day, Year)	injury	work		- 1	ou. Describe i	riow irijai	y occurred	4		
r Atter er dea rector	Certificate	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of I	njury - At ho etc. (Specify		eet, factory, office		28	Bf. Location (or Rural i	Route Numb	oer,
intal or urs aft ral Di			20												
Hosp 24 ho Fune etely f	Medical	(Check 2	🖳 Medical Exam	sician: To the best iner: On the basis o	f examination	n and/or invest	tigation, in my opinio	on, death occur	rred at th	ne time, date a	and place	e, and due t	to the caus	se(s) and ma	nner stated.
To the within To the To the Compl	Σ	only one) 3 29b. Signature and		se Practitioner: To	the best of h	пу кпожеаде	29c. License		ina piace	e, and due to		ite signed			
		Valor	il Arusa	ugh CR	uf		R149	851			08/2	20 20	012		
7		30. Name and addr	ess of person who	completed cause of	f death (Item	1 23a) (Type, F				MAD	_				
Stat		Valane I-(31. Date filed (Mont	n, Day, Year)	32 Aegis	trar's Signal	VREVL	Street p	3011m	1019	MD	412	01			
Registra		,	EP 0 5 20	12 Jane	m /	8. p.	arlis								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1702 Spanish Oak Lane Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 9, 1953 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Vi**r**ginia Director 134-44-6055 1 💢 M 2 🗆 F 58 al Hygiene. I other than "natural", or items 23a or 28e-f show vent, the M∞dcal Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1702 Spanish Oak Lane 20721 death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐XNo Specify: Black Specify: Completed 3 Divorced 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Architect Beverage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Gertrude Williamson Bigelow Marion Napoleon Cooper permit. Page 1 and 2 should be Department of Health and Ment Importent: If item 27 is marke any injury or other treumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11702 Sweetbriar Ridge Drive Charlotte, NC 28269 Natassha Cooper/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/04/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CHRONIC MYELOID Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 5:00 PM Physician/ Month August 30, Year 012 Lou Ann Coleman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Lutherville Baltimore Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours Min. 554-38-4011 Allorth, Po Year 1931 Director Minnesota 1 M 2 X F Yrs Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Baltimore Parkville 1 Yes 2 No o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 23a r Funeral 8800 Walther Blvd. Apt. 3410 21234 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Yes 2 No "natural", or Black, White, etc. þ 1 Never Married 2 Married 5:00 р.ш. filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-24 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Clarence Beacom Covert 19a. Informant's Name/Relationship (Type, Print) 30, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Coleman /Husband 8800 Walther Blvd. Apt. 3410 Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State AUGUST ්ජීව 01 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory Beltsville, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 101443 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ URETHRAL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as the I IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant COLEMAN 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Pregnant at time of death Other (specify) Month Day Year detached Yes 2 X No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANN þe Records, Completed 1 Yes 3 Probably 4 Unknown No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 Yes 2 No Division of Vital or Attending Physician; funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 🗶 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred X Natural 5 Pending injury the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

10V

the

State Registrar

(Check

only one) 29b. Signature and title

31. Date filed (Month

TRACIE L.

30. Name and address of person who corpleted cause of death (Item 23a) (Type, Print)

-MORGAN, CRNP

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e 19b perFH G931, 9/11/2012 WS.

State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 012 Physician/ Sept. Francis Christensen 2, 9:00 p. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month Day Year) Director 215-46-3483 65 1 X M 2 □ F April 28,1947 Oregon 10a. State 10b. County the Manyland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified Gaithersburg Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be 7316 Torran Rocks Way 23a Funeral 20879 United States ural", or items ? I Examiner mus Was Decedent - Armed Forces?

12 yes 2 \(\text{No} \) No Pive \(\text{168-174} \) 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify. White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene item 27 is marked other the other traumatic event, the Meat Cutter Giant Food 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Christensen Mireille Boulanger Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7316 T**TPFSA**ⁿRocks Way Gaithersburg, MD 20879 Lois J. Christensen (wife) It of Hea 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 04. 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2XXCremation 3 Removal from State 2012 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fine at Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): **Examiner** Rectal Cancer 3 months Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transi Cause (Disease Or Injur) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Other (specify) Month Dav Year Pregnant at time of death Yes 2 No detached 1 9 Unknown g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Alchohol abuse 1 Yes 2 No 3 Probably 4 Unknown Completed Depression 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

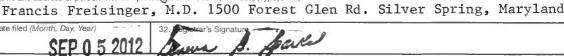
To the Funeral Director: After this certificate has I autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Man of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0070427 Sectember 3

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 2:30P Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 682 Luthardt Road Middle River 8. Date of Birth (Month, Day, Year) 10/07/1952 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Florida Months Director 1 🗆 M 2 🖄 F 264-02-4054 59 Yrs 27 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Macked Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 682 Luthardt Road 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian 1 Styes 2 No Air Force Armed Forces Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify Year or Dates. 7 76 - 9 86 Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Dolphus Cue Sallie Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pege 1 end 2 sh ment of Health a tent: If item 27 h Priscilla Cue / Sister 682 Luthardt Road, Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) 9/3/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licens 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) sta Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physicien and for use as the burial-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760° IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 1 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) al or Attending P s after death. i Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be filled In by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospitel within 24 hours a To the Funerei Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) D003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X thou 2/12 Dundalk 32. Registra 's Signat State Registrar

DHMH 17 Rev 06-2011

		Please 1 State Registrar	Type or Print in Bla State of Maryland	/ Depa		lealth and M	lental Hygi	_	ible.	2 2006			
Physic		Decedent's Name (First, Middle, Last, William Frederich					Date of Death Month	Day	Year 2012	3. Time of Death 5:00 P M			
/Med Exami Funera	ner	4a. Facility Name (If not institution, give FRANKUN SQUARE / 5. Social Security Number 6. Sec. 15	street and number)	t birthday) Yrs.	4b. City, Town, or ROSE I If Under 1 Year Months Days	Location of Death ALE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 16	4c. Count	y of Death	RE			
Maryland -f show		869-65-9572	10c. City, 1		ocation		Aug. 16	, 201.		yLand 0d. Inside City Limits 1 □ Yes ≱ No			
th with the 23a or 28a	Funeral Director	10e. Street and Number 1431 Valley Forge		ngaoi	10f. Zip Code 21009			g. Citizen of	What Cour	ntry?			
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ace - Americack, White,				
21215-0036 d within 72 hours aft giene. er than "natural", or	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired r Worked	ation during most of worki i)	ing .	6b. Kind of E	3usiness/In	dustry			
Maryland ' Id 2 should be filed Ith and Mental Hyg Y is marked othe	To Be C	17. Father's Name (First, Middle, Last) Marc William Ch	rist				Fulton 1	Fultor	ı	- Codo)			
ore, Mar es 1 and 2 sh of Health and litem 27 is n r other traun		19a. Informant's Name/Relationship (7) Marc Christ / Fat 20a. Method of Disposition	ther 20b. Plac	1431		and Number or Rur Forge Way	, Abingdo		arylar	nd 21009			
Baltimore, Mapermit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Svcs, LLC 9-5-2012 Bel Air, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Holling McComas Funeral Ho											
Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. ne cause on each line. a. PULMONARY Due to (or as a consequer	HEN			or respiratory arre	st,		Approximate Interval Between Onset and Death O DAYS			
68760, K	al Examiner	Sequentially list conclitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer c. EXTREME P	ON NECATIVE BACTERIA to (or as a consequence of): TREME PREMATURELY to (or as a consequence of):						I DAY IY DAYS			
U. BOX he death cer the attendir	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	☐ Ectopic pregnand ☐ Other (specify) _	у			ate of deliv	very Day Year			
cords, P. w requires that the seen signed by should be detact	b	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the u	ınderlying cause giv	en in Part i.				the cause of death?			
VItal Hecords, ilclan: The law requires th certificate has been signe rector, page 2 should be of	e Completed	25. Was case referred to medical				Of Place of Post	24a. Was an autopsy perform 1 X Yes 2	ried?	prior to co death?	opsy findings available ompletion of cause of 2 No			
DIVISION OT VITAI I or Attending Physician: T after death. Director: After this certificat d in by the funeral director, ps	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	8b. Time o	of 28c. Inju	er: 4 🗆 Nursing Ho	ome 5 Resider	nce 6 C	urred				
To the Hospital or Attending within 24 hours after death. To the Funeral Director. After completely filled in by the funeral		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			The date and also	28f. Location (Str. City or Town,	State)					
o the Hos Ithin 24 hd o the Fun	Medical		iner: On the basis of examination and manner stated.			opinion, death occur	red at the time, da		e, and due	to the cause(s)			
A 14 50	_	1 80	MD	(2a) /T	Die	7337		-		7,2012			
\		30. Name and address of person who co Sarah Harper	9000 Frankli	n Sa	luare Dr	ive Bat	timore 1	ND 3	2123	,7			
Si Regis	ate trar	SEP 0 5 2012	32. Registrar's Signatur	les									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 4a. Facility Name (if not institution, give street and number) renoweth Za 201 Medical UQI Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A FIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Director 219-42-7269 1 X M 2 □ F 69 1943 Feb. 21, Maryland show 10a, State 10b. County 10c. City, Town or Location Pege 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other then "naturel", or itema 23a or 28a-f sho other traumatic event, the Macheal Examilizer must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? Funeral 12 Deer Pass Court 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Public & Private if Health end Mentel Hygiene, item 27 Is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ William Chenoweth Catherine Charron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Chenoweth Deer Pass Court 21030 Cockevsville, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of Dutattey crevitably beciter place)
Memorial Gardens 20c. Location - City or Town, State Date ō <u>=</u> 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or 9-6-2012 Timonium 4 Donation 5 Other (Specify) Maryland 22. Name and Address of Facility RUCK TOWSON Funeral Flome, Inc. 21. Signature of Funeral Service Licent 1050 York Road Towson, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ultiple system organ.
Due to for as a configuence of): disease or condition resulting in death) a. Multiple Medical Examiner b. aortic arch ansuryen repair Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Divi to (or as a consequence of pete has been signed by the ettending physiclen end pege 2 should be deteched for use es the burial-transit Hospital or Attending Physician: The law requires thet the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s after death.

**Director: After this certificete has autopsy perform 2 🗆 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D completely filled is Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier mo August 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Babak Orandi, MD Maltimore, Md 2/287 1800 Orleans street 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#29d, perPHYS, G931, 9/24/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:16 HN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab. Anne Arundel Ctr. Annapolis 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. (Month, Dav. Year) **Director** 166-24-8812 1 X M 2 🗆 F 81 Pennsylvania Usual Residence of Deceden 29, 1930 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Anne Arundel Annapolis 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 940 Astern Way Unit 109 21401 **United States** death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' 0. Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. "natural", 3
Widowed 4 Divorced Specify: Year or Dates White the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ° Elementary/Secondary (0-12) College (1-4 or 5+) Systems Analyst Department of Defense 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wesley Demler, II Naomi Emma Dahms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Astern Way Unit 109 Annapolis, Maryland 21401 Doris A. Demler / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 🗌 Burial 2 🗶 Cremation 3 🔲 Removal from State August 2012 31, 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Odenton, Maryland Signature of Funeral Service 22. Name and Address of Facility

Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ an disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No the detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has filled in by the funeral director, page 2: autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1
Yes After t Certificate: 28d. Describe how injury occurred 1 CHatural injury 5 Pending 2 🗆 No 2 Accident Investigation 24 hours a er deal Funeral Director 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 ______ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year), 2012 051756 445 DEFENSE HIGHWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cro H Annapolis MD 32. Registratis Signat State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 19b, per fh, g931 9-5-12 sm
State of Maryland / Department of Health and Mental Hygiene 2012 28071 For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ 12.00 PM Medical **Examiner** Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death ltimore 8. Date of Birth 9. Birthplace (State or Foreign last birthday **Funeral** 1 M 2 D F Months Hours Min. (Month, Day **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DQ NQT use retired (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) VR9 Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည 19b. 5009 d Knellet Avenbe Baltitimore Men 21206 tate, Zip Code 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremators or other pla 20a. Method of Disposition 20c. Location - City or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address uneral Service Licens 21. Signature of s of Facility 70 Frac hiltontassi Bulto mo al 229 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Acute mquierdial
Due to (or as a consequence of): Infarction disease or condition resulting in death) 0 Medical Examiner Curuncry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Month 5 Other (specify) Day Year g Unknown To the Funeral Director: After this certificate has been signed i completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 24 hours after death.

Funeral Director: A: 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the 3 🗀 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 09.04.2012 n 43386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #21 31. Date filed (Month, Day, Howard B. 1 L'more 21217 1714 Euten Place mo strar's Signature State 5

Registrar

Box 68760

Records,

Division of Vital

4:00 P M 4c. County of Death Carroll Birthplace (State or Foreign Country) MD 10d Inside City Limits 1 Yes 2XXNo 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Ed Dare Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) Lurlanie LaBeurrier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7419 Old Washington Rd., Woodbine, MD 21797 20c. Location - City or Town, State Winfield, MD 22. Name and Address of Facility Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖎 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 2 🗆 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 08/31/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20, crossroads rive KAWAJA TAHOORA M Dallit 31. Date filed (Month, Day, Year) 32. Registrar's agnature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar			Cer	tificate of L	Death)		Reg. No		2 2807	,
	Physicia		1. Decedent's Name (First, Middle, I Sheree	^{Last)} Rae	Domnir	ng				2. Date of Dea		^{ay} 2012	3. Time of Death 2:35 a. M	
)	Medic Examin		4a. Facility Name (if not institution, g				4b. City, Town, or Bethesd		n of Death		40	c. County of Dea ontgome1	th	_
	Funeral Director		5. Social Security Number 218–92–5177 Usual Residence of Decedent		e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Und Hours	er 24 Hrs. Min.	8. Date of Birt Aug • 1	h	9. Bir	thplace (State or Foreign untry) ssissippi	_
	Maryland 28a-f show notified at	Director	Maryland Montgon	nery	10c. City, To								10d. Inside City Limits 1 ☐ Yes 2 🔀 No	_
	with the s 23a or ust be r	Funeral D	10e. Street and Number 3800 Brooke Mead	low Lane			10f. Zip Code 20832					itizen of What Co ited Sta		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 🕅 Never Married 2 🗌 Marrie 3 🗍 Widowed 4 🗎 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.	Ever in U.S. No		/as Decedent of H Yes, specify Cuba ☐ Yes 2X No			ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.	
Baltimore, Maryland 21215-0036	vithin 72 hou liene. er than "nati the Medica	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	's Education t grade completed) College (1-4 or 5	i+)	(Give k	ent's Usual Occup ind of work done o NOT use retired)	during me	ost of workin	g	16b. k	Kind of Business	/Industry	
/land	d be filed w Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Las Anthony Domning	st)						(First, Middle,		,		_
Man	12 shoul		19a. Informant's Name/Relationship Anthony Domning	(Type, Print) (father)			g Address (Street a				-			
imore,	Page 1 and ment of Hes ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place ceme	of Dispos	e Cremato	ce)		ate 31,	20c. L	ocation - City or	Town, State	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lic	ensee N	100982		Name and Addres						ion Service d 20910	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or cashock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	ations	of	rthe mode of dyin Brain Ste			respiratory arr	est,		Approximate Interval Between Onset and Death 36 years	
	be executed sician and burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a		,								_
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of the line of the li	2 Fetal dea		Ectopic pregnanc Other (specify)	СУ				23d. Date of de Month	livery Day Year	
ls, P.O	uires that the signed by all the deta	by	Part II. Other significant condition:	s contributing to death b	ut not resultin	g in the ur	nderlying cause giv	ven in Pa	rt I.				the cause of death?	
Division of Vital Records, P.O.	The law rec rate has bee page 2 sho	Completed								24a. Was a autop perfo	rmed?	prior to death?	topsy findings available completion of cause of	
Vital	ding Physician: The la h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	Hospital:	ent 2 🗆 ER/0	Outpatien	Othe	er.	eath <i>(Check o</i> Nursing Hom		lence 6	6 ☐ Other (Spec	eify)	
on of \	tending Ph leath. :or: After th the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ation	Time of injury	Time of 28c. Injury at 28d. Describe how injury occurred								
Divis	ital or At irs after or al Direct led in by		4 Homicide determin		ury - At home, c. (Specify)	farm, stre	et, factory, office		2	8f. Location (S City or Tow			ral Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check 2 Medical Exa	Physician: To the best of a aminer: On the basis of ex lurse Practitioner: To the	xamination and	d/or investi	gation, in my opinio	on, death	occurred at t	he time, date a	nd place	e, and due to the	cause(s) and manner stated	d.
	Noth with Con		29b. Signature and title of certifier	MD			29c. License D6798					ust 27,		
1	21		30 Mame and address of person why Yueng Li, M	.D. 8600 01	d Geor	getor	vn Rd. Be	ethes	sda, M	D 2081	4			
	Stat Registra		31. Date filed (Month; Day, Year) SEP 0 5	2012 32. egistra	tr's Signatur	40	wed							

N. W.

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08/27/2012

Domning, Sheree

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:15 AM eresa Medical 4a. Facility Name (if not institution, give st 4b. City Town, or Location of Death 4c. County of Death Examiner Baltimine Bulzimon, MD Siny. 201 nita If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Funeral Months Days Hours Min. 14 (Month Day, Country) Director 1 □ M 2 🖫 F 55 215-64-9950 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Wedical Exercitor must be notified at Director Baltimore 1 ¥ Yes 2 ☐ No NA MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21216 3247 Normount Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or I any injury or other traumatic event, the Medical Exercisions 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled <u>12th grade</u> na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Dennard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
903 South Beechfield Ave, Baltimore, 19a. Informant's Name/Relationship (Type, Print) Md21229 Tamara Scott-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 9/6/2012 Woodlawn, Md Woodlawn 4 Donation 5 Other (Specify) 21. Sign three of Funeral Service Licensee 22. Name and Address of Eacility. March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heartifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ONY Medical Due to (or as a consequen Examiner Sequentially list conditions. if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last a consequence of: Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 🖸 **Division of Vital** Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No |요 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 ☐ Accident
3 ☐ Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medic (Check only one 29b. Cignati 18260 of death (Item 23a) 31. Date filed (Month, Day, Year, 2. Registrar's Sign State 5 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jr Month Ringgold Dorceu 10:30 AM Angust 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-22-9760 Director 1 ÅM 2 □ F 83 12 24 28 MD Usual Residence of Decedent ir then "neturel", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at filed within 72 hours efter deeth with the Merylend el Hyglene. el Hyglene. d other then "neture!", or iteme 23e or 28e-1 eho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 X Yes 2 No NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3339 Dolfield Ave 21215 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Š 1X☐ Yes 2☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Postal Elementary/Secondary (0-12) College (1-4 or 5+) llth grade Mail Carrier Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ehould be file end Mentel H Ringgold Dorsey Sr. Marjorie Matthews t. Pege 1 and 2 abould by tment of Heelth and Mer nant: If item 27 is merky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Carter-Daughter 7803 Howard Street, Manassas, VA 20111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Department of Importent: If eny injury or once. ò Garrison Forest Vet 9/14/2012 Owings Mills, 4 Donation 5 Other (Specify) 21. Signature of Fundamental Service, Lice 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer Physician/ prostate disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours efter deeth.

To the Funerei Director: After this certificate has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be detached for use as the burlel-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ icete has been sig 7, pege 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ရု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rajupahre MD D0057465 8/31/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

N) & Rajuparese MD

31. Date filed (Month, Day, Year)

SMITH

2835

32. Registrar's Signature

AV 5203

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 William Clayton Dixon Sr. Sep. 9:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 803 A Cashew Court Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours (Month, Day, Year) 213-18-6253 Director 1 🕱 M 2 🗆 F 92 2, 1920 Aug. Maryland or than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛂 No Maryland | Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 803 A Cashew Court 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Tool Design Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be flle Department of Health and Mentel I Importent: If Item 27 Is marked o ည Anna (unk) Middlecoff Eugene (unk) Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1537 Redfield Road, Bel Air, Maryland 21015 19a. Informant's Name/Relationship (Type, Print) Michael Dixon / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Protestant Epis. Cem. 20c. Location - City or Town, State ō 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland any injury o 4 Donation 5 Other (Specify) of Funeral Service Licenses 21. Signature 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consultance of): Examiner 6 Mon/ hs Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Dire to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes e a 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner. So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item) 23a) (Type, Print)

2021 3 EM WOYON KOOD SUK ZIO BELLING MIT 21015 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 28077

		1- For State Certificate of Deat.	h	Reg. I	No.	
Physician Medical Examine	1/	Decedent's Name (First, Middle,Last)		Date of Death Month Da August 23, 2	ay Year 012	3. Time of Death 0145 hrs
	-		own, or Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undo Month 217 − 96 − 8455 1 M 2 F 62 Yrs.	er 1 Year If Under 24Hrs. s Days Hours Min.	_	1950 9. Bird	hplace (State or n untry) WI
ow any	ľ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore CO.	Pikesville			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Ulrector	10e. Street and Number 7404 Monita Rd.		10g.	Citizen of What Cou	ntry?
er death w	Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	can Indian, Black,
2 HE	leted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Dccupation (Give kind of v rking life. DO NOT use reti	red)	Sb. Kind of Business/	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than te event, the Medica	91	17. Father's Name (First, Middle, Last)	ng Assista 18.Mother's Name Floren	(First, Middle, Maid		Nursing
	To Be	Kambon Williams 7404 Mo	(Street and Number or F	Rural Route Number Pikesvi	ir, City or Town, State, Zip Code)	
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N important: If item 27 is in jury or other tranmatic		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 20b. Place of Disposition (Nau crematory or other place units) 8 Belgrove FH	me of cemetery, unk	Date 2	Oc. Location - City or Chaguanas, Baltimor	Town, State Trinidad MD
Baltimore permit. Pages 1 Department of F Important: Ui injury or other	-	21. St nature of Funeral Service Licensee 22. Name and	ph Brown N. Fulton	Ave., Ba	altimore	me PA , MD21217 Approximate Interval
Physician Medical Examiner	ŀ	27a. Part I. Enjerthe disease, or complications mat caused the death. Do not enter the mode failure. Life only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or dying, such as cardiac o	respiratory arrest,	onesi, e, nesi	Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
uted nd ransit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	A / 1 0 mm			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED #1 PER ME G931 9/2 #20b.c.perFH,G931,G #5 perFH,G931,G #5 perFH,G931,G #6 perFH,G931,	0/12 TRT 0/19/2012,WS	Đ.	23d. Date of deliver	у
Box 687/e e death certifica	Physician/	23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregna	ancy	Month	Day Year
P.O. E				23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be deached for use as the superal process.	Completed by			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of es 2 No
tal Rician: 1	å	25. Was case referred to medical examiner? Hospital: Innation: 2 FR/Outpatient 3	26.Place of Death (Check		esidence 6 Othe	г.
on of Vinding Physiath. **After this he funeral di	tion: To	1 V Yes 2 No 28a Date of Injury 28b, Time of Injury	28c. Injury at Work?	28d. Describe how		
Division ital or Atto urs after deserted birecto	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factor (Specify)	y, office building, etc.	28f. Location (Stre or Town, Stat		ural Route Number, City
Fo the Host within 24 ho Fo the Func	Medical C	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in manner stated.	y opinion, death occurred	at the time, date an	s) and manner as sta d place, and due to the 29d. Date signed (Mo	ne cause(s)
	Σ	Celiner (A)	O.C.M.E.		August 29, 2012	
1		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimo	ore Street, Baltimore	, MD 21223		
Sta Registi						

12-06419 Bernard Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

mara Bavis			tificate of Death	Reg. No.	112 2807
Physic edical Exan	ian <i>i</i> nine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year August 25, 2012	3. Time of Death 1721 hrs
The state of the s		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore		
Funera	i	Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. la			
Directo		220-64-5796 13M 2 F 56	Yrs. Months Days Hours Min	08/08/1956	oreign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d Inside City Limits
Maryland 28a-f show d at once.	Į į	MD N/A	Baltimore		1 X Yes 2 No
r with the Maryland ms 23a or 28a-f sho	Director	10e. Street and Number 1600 E. Chase St.	10f. Zip Code 21213	10g. Citizen of What	
th with 1 cms 23s	Funeral		S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		American Indian, 8lack,
fter dea I", or it	by Fur	3 VVidowed 4 Divorced IT tas, Giva tear	1 Yes 2 X No specify:	Specify:	Black
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1036 Aithin 72 ene.	Completed	unk	Laborer	City o	f Baltimore
21215-0036 Muld be filed within 7 Mental Hygiene. II. riced other than event, the Medica	မ္မ	17. Father's Name (First, Middle, Last) George E. Davis		e (First, Middle, Maiden Surname) la Wallace	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and the matter of Health and Mental Hygiene, and the state of the 27 is are yeld other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Print) Karen Davis(sister)	19b. Mailing Address (Street and Number or 13036 E. Federal St	Rural Route Number, City or Town,	
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition 20b. P	Place of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - C	
Baltimore, sernit. Pages I ar Department of Her Important: If ite injury or other tr		4 Dogatico 5 Other Specify:	-site Creamtory 🔏	3/-/2 Baltim	
Baltimo permit. Page Department of Important:		21. Signature of Funeral Service Licensee	Joseph H Brown 2140 N. Fulton	Jr. Funeral H Ave., Baltimo	ome PA re, MD 21217
Physiciar // /Medica		23a. Part I. Enter the disease, or complications that eached the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac of		Approximate Interval 8etween Onset and
Examine		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiova Due to (or as a consequence of)			Death
	ē	Sequentially list conditions, if any, leading to immediate b):		
	Examiner	cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·	
executed an and al - transi	calE	d d			
760, cate be or physicia	Medical			23d. Date of de	livery
Box 687 e death certific the attending ped for use as the	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregnath 5 Other (Specify)	ancy Month	Day Year
j. Bo the deat by the at	Phys	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
tal Records, P.Ö. Box 68760, ciam: The law requires that the death certificate be executed certificate has been signed by the attending physician and econ. nase 2 should be detached for use as the burial - transit	A p			1 Yes 2 No 3	Probably 4 V Unknown
cords law requested has been	Completed			autopsy pric	re autopsy findings available or to completion of cause of other
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of Vital ing Physician: After this certifiums all director.	0	Tes 2 No			Other:
on of canding Phasath. or: After the funeral	tion:	27. Manner of Death 1 Natural 5 Pending Pending	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
Division of Vital Records, pital a Records, ours after death. For After Mending Physician: The law requirement Director. After this certificate has been siftlied in by the funeral director, nage 2 should it	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	or Rural Route Number, City
in a min		(Check only 1 Certifying Physician: To the best of my knowledg			
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	ad/or investigation, in my opinion, death occurred a		to the cause(s) (Month, Day, Year)
		Ofly Bull Mas	O.C.M.E.	August 26, 2	
21		30. Name and address of person who completed cause of death (Item. Melissa Brassell, MD Assistant Medical Examin	^{23a)} er 900 W. Baltimore Street, Baltimo	ore, MD 21223	
Regi	State	31. Date filed (Month, Day, Year) 32. Registrar's Signatur			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ Rapheal Reuven Evans 2012 10:58 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 85 112-20-1553 1**X** M 2 □ F New York 4-4-1927 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Rockville Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 503 King Farm Blvd. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1X Yes 2 No WWII Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Business Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked other treumetic ev Dina Ader Page 1 end 2 should be innent of Health and Menta Max Maxwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 shr Department of Health an Important: If item 27 is any injury or other treu. 503 King Farm Blvd., Rockville, Maryland 20850 Paula Evans - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 09/05/2012 Farmingdale, New York 4 ☐ Donation 5 ☐ Other (Specify) Beth Moses 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brad Smetzer 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disea shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ respirat OV disease or condition resulting in death) Medical Due to (or an a consequence of Examiner 45102 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine oneumo thorax attending physician end for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to/(or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ oulmo han otenosis Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed Yes 2 After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

completely filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signate e and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roduille, carpenter, MD 9901 Midical Center 32. Regi State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28080 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Ruth Epstein 23:59 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 3112 Gracefield Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) **Director** 092-14-5410 1 M 2X F 91 3-3-1921 New York permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itams 23a or non any injury or other traumatic event. The Water 1000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Silver Spring Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Gracefield Road 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sylvia C. Saks Benjamin Horowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marty Epstein - Son 10004 Dellcastle Road, Montgomery Village, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State Farmingdale, New York 9-7-2012 4 ☐ Donation 5 ☐ Other (Specify) Beth Moses Cemetery . Signature of Funeral Service Licensee Edward Sagel 22. Name and Address of Facility Danzansky-Goldberg KIN 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Years Immediate Cause (Final Physician/ Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that injured excepts. Examine Due to (or as a consequence of) attending physician and for use as the burlal-transl Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Day ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060634 9-1-2012 \wedge 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Bindu, MD - 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State Registrar N. Charles St. Baltshuse NID 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

60

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name / Eirst. Middle. Last 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. Off, Town, or Location of Death Examiner atonsville timore If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) curity Number Country) Funeral Months Min (Month, Day, Year 7888 Director 1 M 2 WF δ 6 or then "natural", or items 23a or 28e-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Homore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21207 SP nes 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black White etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retire) permit. Paga 1 and 2 should be filed within 72 Department of Haalth and Mental Hygiene. Importent: If Item 27 is marked other then eny injury or other treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Be Middle, Last) st, Middle, Maiden Surna ၉ nant's Name/Relationship (Type, Number, City or Town, State, Zip Code) ۵ eva 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Himore 4 Donation 5 Other (Specify) 21. Sign sture of Funeral Service License neral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be axacuted 24 hours after death that initiated events Due to (or as a conse resulting in death) Last physician Physician/Medical Box 68760 tha. the attanding photostal IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months
1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) ad by the a Records, P.O. To the Hospital or Attending Physician: Tha law raquires that within 24 hours after daath.

To the Funerel Director: After this cartificata has baan signad it complataly fillad in by tha funaral director, paga 2 should ba dat Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) علا 🗆 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner as stated.

Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, 8 of death (Item 23a) (Type, Print) UBVC 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 7 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12:37 p_M Year Physician/ Month 8-31-P4y2 William Scott Funger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9736 Sorrel Avenue Montgomery Potomac If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) Hours Min Director 218-52-5401 1 X M 2 □ F 54 9/15/1957 DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9736 Sorrel: Avenue 20854 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🗓 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Lega1 Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Normalee Cohen Morton Funger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9736 Sorrel Avenue Potomac MD 20854 Holly Funger/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 A Removal from State cemetery, crematory or other place) 9/4/2012 4 Donation 5 Other (Specify) Falls Church, VA National Crematory . Signature of Funeral Service 22. Name and Address of Facility Edward Sagel Funeral Direction Men <u>1091 Rockville Pike Rock</u>ville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): _ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) ettending physician and for use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 L 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မြ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work? 1 ☐ Yes 2 ☐ No eral Director: A filled in by the f М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) DC19655 9-4-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John L. Marshall, MD 3800 Reservoir Rd. NW Washington, DC 20007-2113 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar OHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a PER FH G931 9/11/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical Month 6.50 AM ity, Town, or Location of Death 4a. Facility Name (if not institution, give street **Examiner** County of Death Baltimore atonsville ge (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Min. (Month, Day, Year) Director 1 M 2 F 3 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD 1 Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc.
Specify: Black þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ndary (0-12) College (1-4 or 5+) Be 17 Father's Name (First, Middle, Last) Name (First i Middle, Maiden Surname) Bernaderte Perry great niece City or Town, State, Zip Code) Mailing Address (Street and Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licen once. tonfass Ballo.MD 21229 of the disease, or complications that caused the death. Do not enter the mode of dying, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock or heart failu Immediate Cause (Final Physician/ HYDERTROPHIC OBSTRUCTUE CARDIOMYD disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant regnan rast 12 months? I ∐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BLEEDING Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed REGURGITH 184a) Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has SEVERE this certificate Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 A Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0018362 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Komal K. Paug M.D. 3455, Will Ste L10. Md 21200 32. Regis rar's Sig State

DHMH 17 Rev 06-2011

Registrar

Funeral Director 23a or 28a-f shov

Box 68760 FITZGERALD

31,

AUGUST

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month August 31, 6:15 PM Physician/ Year 01/2 Fitzgerald Lorraine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Lutherville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **81** 8. Date of Birth 9. Birthplace (State or Foreign 218-28-9690 Oct 23, Year 1930 New York 1 M 2 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1_Xes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 1601 E. Belvedere Avenue United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give White 3 ₩idowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) Own Home Home Maker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Hauser Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Eisenhuth / Grand daughter 426 Greentree Circle Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sep 05 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee M01443 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year 2 **X** No 1 Yes 2 2 Unknown the a been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Division of Vital Records, 3 Probably 4 Unknown 1 Yes the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a, Was an Director: After this certificate has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a e of death (Item 23a) (Type, Print) JACKIE JÖNES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #State of Many and Debath 2012 of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Felton Maggie Dorothy 30a 08 Medical 4accacing Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchirst Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12 Nonth, Pay Days Hours Min. Country) Director 215-28-5087 Usual Residence of Decede 1 M 2 XF 82 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Experiment intal be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director ¹X☐ Yes 2 ☐ No Baltimore MD NA 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 21215 3908 Fordleigh Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Care Giver 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Jordon Philonius Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5430 Lynx Lane #111, Columbia, Md 21044 19a. Informant's Name/Relationship (Type, Print) Sharon Felton-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 5 Other (Specify) King Memorial Park 9/10/2012 Woodlawn, Md 21. Signature of Fureral Service Licen 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Aspiration months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and ched for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 topnths?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58363 AUGUST 31 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST M CHANUES 31. Date filed (Month, Day, Year) State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fernandez Hortensia 201 9:00p 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oblate Sisters of Providence If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Months Davs Hours Min. 220-60-8810 1 □ M 2 F Director 1 02 13 Cuba 98 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 U.S.A. 701 Gun Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 Yes 2 ☐ No Specify: Hispanic Specify. Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5yrs+ Elementary/Secondary (0-12) School Teacher 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ည Caridad Betancourt 2 should be Agustin Fernandez 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number City or Town State Zip Code) L Gun Road, Baltimore, Md 21227 permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any Injury or other trau once. Sister M. Clarice Proctor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Loudon Park 9/6/2012 4 Donation 5 Other (Specify) Baltimore, Md 21. Signature Uneral Service L March F/H West 4300 Baltimore, Md 21215 Wabash Ave, 23a. Part 1 ofter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ onges disease or condition 4 Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence on: or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physiclan/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or: After this certificate hes been signe the funeral director, page 2 should be of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) Convent Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 🔲 Suicide 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

2. Registrar's Sig

Charce have St # 304

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

umms

225GREEHE ST

BALTO MO 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SO ANNI SIKORA, CRNP

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ <u>Harry</u> Godwin 05:12 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7155 Baltimore Annapolis Blvd Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours 1171071944 218-42-2594 **Director** 67 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland **Funeral Director** 10d. Inside City Limits must be notified Anne Arundel Glen Burnie MD 1 Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 7155 Baltimore Annapolis Blvd 21061 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 68 ö Completed by Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2X No Specify "natural", 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 68-70 Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Enterprise Elevator Steel Fabricator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Gertrude Prince Alexander Godwin 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 si Department of Health an. Important; If item 27 is n any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7155 Balt. Annap. Blvd, Glen Burnie, MD 21061 Wanda Kay Godwin/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ ponation 5 ☐ Other (Specify) cemetery, crematory or other place 09/06/2012 Brooklyn Park, MD Cedar Hill Cemetery e p to eral 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Signa rvice Licensee 421 Crain Highway SE, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on e erval Retween Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 L 1 Yes Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Tyes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural in 24 hours after deaun.
The Funeral Director: Aff 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, the within 7

3altimore, Maryland 21215-0036

Box 68760

P.O.

0

203 Hospital Drive Ste 312, Glen Burnie, MD 21061 Poornima Sharma, MD 31. Date filed (Month, Day, Year,

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

50070915

29d. Date signed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3ADREAU Physician/ Month O epH 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 327 Old Riverside Rd. Brooklyn Park Anne Arundel Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 224-20-2882 Hours Director 1 🗓 M 2 🗆 F 84 Oct. 31, 1927 Tennessee parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or items 23a or 28e-f show eny injury or other traumatic event, the Medical Exertiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Anne Arundel Brooklyn Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 327 Old Riverside Rd. 21225 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🔯 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Selection Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph F. Gadreau Hilda Helmadollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosie E. Gadreau / Wife 327 Ol Riverside Rd., Brooklyn Park, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Sept 6, 2012 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Ind. Catonsville, Maryland a of Funeral Service Licensee 22 Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEART FAILURE CONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir To the Hospital or Attending Physicien: Tha law raquiras that the daath cartificata be exscuted within 24 hours attendant.

To the Funeral Director: Attarthis cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the unfal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTEN SIDN Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗆 No Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 🛛 No ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinating and/or investigating in my antique data. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14774 471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID AZIZ 97.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arundel 4187 Solomons Island Road Anne Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 577-32-3749 1 □ M 2 🗓 F 84 05/14/1928 Michigan Usual Residence of Deceden "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20776 4187 Solomons Island Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Mamed 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cosmetology Hair Dresser Page 1 and 2 should be filed with thrent of Health end Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, in Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Groleau Edmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4463 Solomons Island Rd., Harwood, MD 20776 Janice Fergus / Daughter Baltimore, permit. Page.
Department of Her
Important: If iter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 108/31/2012 | Hanover, Maryland Anatomy Gifts Registry . Sign Ture of Funer Service Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Iro Vascv years Medical Due to (or as a consequence of): Examiner RYUSC 10 ean Sequentially list conditions, if any sading to infractiate cause. Enter Underlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed burial-transit 2 lahe that initiated events Due to (or as a consequence of): resulting in death) Last ed by the ettending physician detached for use as the burlal Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown q T Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pege 2 should be 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, is 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 500 116 Defense Hwy, Ste. 400, Annapolis, MD 21401 31. Date filed (Mor)th, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Robert Gordon 2012 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 217-46-9099 1 X M 2 □ F 65 Yrs. 7-5-1947 Washington, DC shov 10b. County 27 is marked other then "netural", or items 23a or 28e-f sho treumatic event, the Medical Experiment has the notified at 10a. State 10c. City, Town or Location Director 10d Inside City Limits Bethesda 1 X Yes 2 ☐ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4603 Woodfield Road 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? 1 K Yes 2 No 1972 Black, White, etc. þ 1 Never Married 2 Married Page 1 end 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ent: if item 27 is marked other then "neturai", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White 1980 Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Frances Fox Frank Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2: Depertment of Health Importent: if item 27 eny injury or other troonce. Carol Blum Gordon - Wife 4603 Woodfield Road., Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Dremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-3-2012 National Crematory Falls Church, Virginia 21. Signature of Funeral Service Licensee Edward 22. Name and Address of Facility Danzanskyy-Goldberg Sage1 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Parkinsons Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No signed by the a d be detached f 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy his certificate has bil director, pege 2 sl performe 1 ☐ Yes 2 ☐ No ☐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 44 Nursing Home 5 Residence 6 Other (Specify) 욛 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours and To the Funereil completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sas, uns D0057124 8-31-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD - 10110 Molecular Drive, #206, Rockville, Maryland 20850

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

SEP 0 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Louise S. Grove August 30, 2012 4:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arcola Health & Rehab Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **Director** 230-16-2500 1 □ M 2 🛛 F 94 Jun 7, 1918 Virginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 901 Arcola Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) US Postal Service Postal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Swortzel Lena Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Moore/daughter 9700 W. Bexhill Drive Kensington, MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 💆 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Final Journey Crematory 09/04/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ a Vascular Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease of injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2X No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Cher (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitions to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 8/3//12 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENSINGTON, MA Rosenbaum FARRAGUT 20875 3720 BARRY 31. Date filed (Month, Day Year) State Registrar

4.70 Pm

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26, per phy, g931 9-5-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar 28094 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alberta Scott Gaither 11:07a M Medical 08 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2326 West Mosher Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) 220-22-9429 Director 1 🗆 M 2 🔀 F 86 Yrs 10 21 26 MD Usual Residence of Decedent ?7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Direct MD NA Baltimore ¹X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2326 West Mosher Street 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 27 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married within 72 hours after \$ Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Internal Revenue Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Secretary Service Be Page 1 and 2 should be filed vent of Health and Mental Hy, ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Perry Bell Scott Cora Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Gaither-Husband 2326 West Mosher Street, Baltimore, Md 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) \$/29/2012 Rest Hanover Md ignature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Phr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause in each line. Approximate Interval Between mediate Cause (Final Onset and Death Physician/ disease or condition mer no Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Tue to for as a constituence of or Attending Physician: The law requires that the death certificate be executed the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be Records. 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy this certificate 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Yes 2/No Other: 1 Inpatient 2 ER/Outpatient 3 DOA me 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number van us death (Item 23a) (Type, Print) 31. Date filed /M Registrar's Sign State 2012 Registrar

2-06591	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lo	egible.		
liguel Angel Garcia	State of Maryland / Department of Health and Mental Hygiene		2012	281
1- For State	Certificate of Death		2012	400

Miguel Angel Ga		1- For State Certificate of Death	2012 28095 Reg. No.
Physici	an/	I MODID	Death 3. Time of Death
Medical Exami	ner	er Miguel Angel Garcia Septem 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	nber 1, 2012 0038 hrs
		Washington Adventist Hospital Takoma Park	Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of	f Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		219-02-7153 1 M 2 F 61 Yrs. Months Days Hours Min. 09/	23/1950 Foreign Country Salvador
		Usual Residence of Decedent	
w апу		10a, State 10b, County 10c, City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
yland f show once	ģ	MD Prince Georges Hyattsville 100. Street and Number 100. Zip Code	10g. Citizen of What Country?
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Director	10e. Street and Number 402 Chillum Road Apt. 102 10f. Zip Code 20783	El Salvador
n with	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
or ite	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No	i i
s after	þ	3 Widowed 4 Divorced IT Yes, Give Year 1 X Yes 2 No specify: Ball V aug.	16b, Kind of Business/Industry
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Tob. Kind of Business/Industry
036 thin 7 than edical	nple	Restaurant worker	Restaurant
MD 21215-0036 12 should be filed within 72 ho th and Mental Hygiene. 127 is marked other than "na umnite event, the Medical Ex	ပ္ပ	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Last)	
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imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,	မ		
- 2 - 9 -		Blanca Luz Garcia-Valdez 3322 Chauncey Pl., Mt. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date	20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimo permit. Page Department of Important: injury or otd		4 Donation 5 Other Specify: Family Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility II. II. Do	Daniel Hemo
Ba Depa Injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bar Wanda C. Baren CC0361 3447 14th St., NW Wa	shington, DC 20010
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory	
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Acute Alcohol Intoxication	Death
Xdmmer		or condition resulting in death) Due to (or as a consequence of):	
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated c	
ed	Exa	events resulting in death) Last Due to (or as a consequence of):	
certificate be executed anding physician and use as the burial - transit	dical Examiner	M UNPENDED AMENDED 23a, 27, 28a-f, per me, g931 9-14-12 sm	
60, ate be hysici e buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
tox 68760 eath certificate be attending physic for use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
Box (e death ce the attence of for use	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	
that the done by the detached	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Di	id tobacco use contribute to the cause of death?
ords, P.O. w requires that the same by same by should be detach	by		Yes 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the finneral director, page 2 should be	Completed	24a, W	
Reco The law cate has	Ē		utopsy prior to completion of cause of death? □ S 2 No 1 Yes 2 No
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ion of Vital I tending Physician: eath. ior: After this certifi the funeral director,	o Be	O 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5	Residence 6 Other:
ing Ph After t		27 Manner of Death 28a Date of Injury 28b Time of Injury 128c Injury at Work? 28d Descri	be how injury occurred
ion ttendi death. ttor:	읉	Natural 5 Pending Fd 8-31-12 Fd 23:58 pm 1 Yes 2 X No subjection	ect ingested alcohol
Divisions spital or At tours after discrete in Direct filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town	on (Street and Number or Rural Route Number, City n, State) 402 Chillum Rd.
Division Hospital or Attene 24 hours after death Funeral Directors stely filled in by the			sville,MD.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for 1	ical	Zay Letting 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the concern of the co	ause(s) and manner as stated. ate and place, and due to the cause(s)
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	-	D A. (1) (1) (2) O.C.M.E.	September 1, 2012
		30. Name and address of person who completed cause of death (Item 23a)	
ک		Ramela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223
St	ate	te 31. Date filed (Month, Day, Year) SEP 0 5 2012	
Regist	trar	SEPUS 2012 Jenus p. garan	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sallye Goldberg Physician/ Day Month 8: 204 M August 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GRISTMILL COURT, PIKESVILLE BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours 217-07-0989 Director 1 □ M 2 🗓 F 93 Yrs. 10/23/1918 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 GRISTMILL COURT, #101 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ JOSEPH ROSEN CORTNICK REBECCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK SETREN/SON 16 SHADED GLEN COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 09/02/2012 WOODLAWN, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Mars la 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END-STage CardiomyopaThy enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). been signed by the attending physiclen end should be detached for use as the buriel-transit or Attending Physicien: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month Day Vear g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physicien: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sig completely filled in by the Tuneral director, page 2 should it. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicíde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MSRegarportheMD 29d. Date signed (Month, Day, Year) 20057465

15√ State

Registrar

DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSQUAPAKSEND 2835 Smin AV

N S Raya Par K SCIND 31. Date filed (Monthi, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Day Physician/ Year 2:15 AM eptember 03 Gilbert Douglas Hensel 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 23 1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 216-24-3519 Director 1 X M 2 D F 82 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Millersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8387 Brookwood Road 21108 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Box Company Q Printer e 1 and 2 should be filed wit of Health and Mental Hygie of Health and Mental Hygie If item 27 is marked other or other traumetic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Importent: If item 27 is marke eny injury or other traumetic e Lester Hensel Emma Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenora Coble (daughter) 9165 Starling Wing Pl. , LasVegas, NV 89143 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery Sept. Date 06 20c. Location - City or Town, State 1 Donation 5 ☐ Other (Specify) Glen Burnie, MAryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 9 23a. Part 1 Einer the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final NEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami The law requires that the death certificate be executed Cause (Disease or ilijury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 🔲 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 00073466 September 3 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital drive Glen Burnie MD 2061 32. Regist ar's Signature State Registrar

50

12-06538 Donte Harris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ertificate c	of Death		F	Reg. No.	2017	2 2809
Physici edical Exam		Decedent's Name (First, Middle, La Donte Harris	ast)				2. Date of De Month August 3		Year	3. Time of Death 0753 hrs
Culcar Exam	mei	4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town,	or Location of Dea			County of Death	
		Sinai Hospital			Baltimore				N/A	
Funeral		Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Y				D/YYYY) 9. Birt Foreig	
Director		213-33-0240	X M 2□F	21 Y		ays Hours M	in. 4/20	/199) 1 Co.	untry) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ation			-		10d. Inside City Limits
▶		MD N/A		altimo						1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	
the M a or 2	Ö	843 Lennox St	reat Ant E		21	217		т	JSA	
death with the Maryland or items 23a or 28a-f sho must he notified at once.	era	11. Marital Status	12. Was Decedent Ever in t		as Decedent of I	Hispanic Origin? (an, Mexican, Puer				can Indian, Black,
h	Funeral	1 Never Married 2 Marrie	1 Yes 2 No				to Moan, etc.)		pecify: Bla	ak
5-0036 lied within 72 hours after Hygiene. t other than "natural", the Medical Examiner.	<u>م</u>	3 Widowed 4 Divorce	If Yes, Give Year or Dates: only highest grade completed)	16a. Decede	Yes 2 X 1	No specify: pation (Give kind o	f work done		nd of Business/Ir	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during r	most of working li	fe. DO NOT use re		102.10		iddolly
vithin ene.	I d	10th	N/A	lal	oorer			Vai	cious 3	Jobs
D 21215-0036 should be filed within 72 hours after and Mould Bygiener 7 is marked other than "matural", of natic event, the Medical Examiner:		17. Father's Name (First, Middle, Las	•				ne (First, Middle,		,	
212 ald be Menta marke	To Be	Clarence Har: 19a. Informant's Name/Relationship	T1S Type, Print)	19b. Mailir	ng Address (Str	Jacqu eet and Number o	ielyn C	urri	or Town State	Zip Code)
sho and 7 is	-	Jacquelyn Gil	bert-Mother			st. A		_		
ore, MI es 1 and 2 s of Health a If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3			sition (Name of		Date	20c. Lo	ocation - City or	Town, State
Pages Pages nent of		4 Donation 5 Other Specif		-		tory 9	/12/201	2 Ba	altimo	re, MD
Baltimore permit. Pages 1 Department of 1 Important: If injury or other		21. Signature of Funeral Service Lice	ensee			ess of Facility				
		23a. Part I. Enter the disease, or com	entications that caused the deat							Approximate Interval
Physician √Medical		failure. List only one cause on e	each line.		the mode of dynn	g, saar as cardiac	or respiratory at	1631, 31100	r, or near	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Gunshot Wound of He Due to (or as a consequence							
		Sequentially list conditions,)							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):						
d sit	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
760, icate be executed physician and the burial - transit		UNPENDED	AMENDED							
760, icate be e physicia the buria	Medicai	IF FEMALE:	23c. If yes, outcome of pre	onancy				234	Date of delivery	
certifica nding pl	_	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 🔲 F	etal death 3	Ectopic preg	nancy			ay Year
atte or u	Physician	1 Yes 2 No 9 Unknow	Pregnant at time of d	eath 5 C	other (Specify)	_				
₩ 5 4 5		Part II. Other significant conditions		resulting in the	underlying cause	e given in Part I.	23e. Did t	obacco us	se contribute to t	he cause of death?
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by tuneral director, page 2 should be detach	d by						1 Ye	s 2 🗹	No 3 Prob	ably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law required and the death. The rhis certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second the control of the contr	Completed						24a. Was auto			opsy findings available empletion of cause of
Recc The lay cate ha	E O						perfo 1 ✓ Yes	rmed?	death? 1 ✓ Ye:	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	Handali —			ce of Death (Chec	k only one)	-		To deliver the second
f Vi Physic or this ral diru	횬	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2				28d. Describe	Residenc		
nding th.	io ::	1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year) FOUND:	28b. Time of FOUND:	1 200. 11	jury at Work? Yes 2 ✔ No	Subject sho	, ,	occurred	
risic r Atter er dea irector	ficat	2 Accident Investiga	28e Place of Injury - At I	0630 hrs nome, farm, stre	eet, factory, office		28f. Location (Street and	Number or Rur	al Route Number, City
Div iital or urs aft iral Di	Certification:	3 Suicide 6 Could no determinate	t be				or Town,	State)	e Avenue, Ba	
Division of V To the Hospital or Attending Physical Attending Physical Division of Attending To the Funeral Director: After this completely filled in by the funeral di			clan: To the best of my knowle							
To th withir To th	Medical	one) 2 Medical Examine 29b. Signature and title of certifier	er: On the basis of examination and manner stated.	and/or investiga			at the time, date			
	2	255. Signature and the or certifier	golan			nse number C.M.E.			ite signed <i>(Mon</i> st 30, 2012	ui, ⊅ay, rear)
SNA		30. Name and address of person who		m 23a)				1 -94		
2014		Carol H. Allan, MD Ass	sistant Medical Examine		Baltimore St	reet, Baltimor	e, MD 21223			
S Regis	tate	31. Date filed (Month, Day Year) SEP 0 5	32. R. gistrar's Signa	ture	ares					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MINNIE Physician/ Month Year 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTI CROMWELL BALTIMONE MOURE 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 6/2471925 1 M 2 X F 87 Yrs Director 250-54-3598 Usual Residence of Decedent ural", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 🗌 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 8710 Emge Rd. 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exar Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Home Care Domestic permit. Page 1 and 2 should be filed w Department of Health and Mental-Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Booker Fronzalee Seagers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Holmes-Son Terrance Danbury, CT 06811 Bristol 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) On Cremation: 9/5/2012 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East Brench Mullin Baltimore, Ε. North Ave. MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final DEMENTIA Onset and Death Physician/ END disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed Yes 2 Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location /Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		н	For State		State of M	1aryland					and M			201	2	28100
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)					OI D	eatri		2. Date of Dea	Reg. No.	201		3. Time of Death	
F	Physicia	n/	Alberta I		,							Month 09	Day 01	Yea 201	r I	12:58 PM
	Medica Examina		la. Facility Name (if no					4b. City, To	own, or I	Location o	of Death			County of De		12.50 111
	LXamin		4 Cedar R	idge Co	urt			Kin	gsvi	lle				Baltin	ore	
	Funeral	1	5. Social Security Number	per 6. Se	7. A	ge (In yrs. las	t birthday)	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Birt		9. E	Birthpla Country	ce (State or Foreign
	Director		216-24-949 Usual Residence of D		□м2₩ ғ	84	Yrs.					03/26/1				and
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fil the	a or 2 be no		10e. Street and Number	r				10f. Zip 0	Code					zen of What	Country	?
h with	ns 23 must	Funeral Director	4 Cedar F	Ridge Co					087		. 0.10	'' Y N		S.A.		
0 W) 36	or iter	by Fu	 Marital Status Never Married 	2 Married	12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give	Ever in U.S.	13. W	as Decede Yes, specif	nt of His y Cuban	panic Orig , Mexican	gin? (Speci i, Puerto R	ify Yes or No- lican, etc.)		14. Race - Ar Black, Wi		
f 0	ral", C	g p	3 X Widowed 4		If Yes, Give Year or Dates.	L NO	1	Yes 2	X No	Specify:			1	Specify: V	hit	e
21215-0036 within 72 hours after death with the Maryland	"natu dical	Completed		5. Decedent's Ed only highest gra			16a. Deced	ent's Usual ind of work	Occupa done du	tion urina most	t of workin	a	16b. Ki	nd of Busines	ss/Indu	stry
121 Thin 73	than than	mo	Elementary/Second		College (1-4 or	5+)	life. DC	NOT use r	etired)			S		Own Ho	me	
	Hygie other ent, th	as F	12 17. Father's Name (Firs	t. Middle. Last)			нопе	makin		18. Mothe	er's Name	(First, Middle,			AIIC	
lan be fill	ental rked c	2	Walter Me		mond							Albert				
Maryland 2 should be filed	alth and Mental Hygiene 27 is marked other th r traumatic event, the		19a. Informant's Name									Route Number				
e, N	Health tem 27 i	-	Diana L.		(daught	er)	1332	Sprin	gda]	le Dr	ive -	- Bel A	ir,	Maryla	and	21015
ALB altimore,	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispos 1 🔀 Burial 2 🗆		Removal from Stat	_ cer	ice of Dispos metery, crem	atory or oth	er place	e)	_	ate		cation - City		
Baltimor	rtmen rtant:	ļ	4 Donation 5	Other (Specif	y)	Sale	m U.M	. Chu	cch	Cem (09/05	72012 Tage	Uppe:	r Fall	S, I	Maryland ome, P.A.
Bal	Depa Impo any ir		21. Signature of Funer	al Service Licens	oosah m	j						Kingsv				
			23a. Part 1. Enter the shock, or heart fa		olications that cause ne cause on each li		Do not ente	r the mode	of dying	, such as	cardiac or	respiratory arr	est,		Δ	pproximate Iterval Between
	ysician/		Immediate Cause (Fin disease or condition	al	MYOCH	ARDIA	FL 1	NFA	RC	T10	N					inset and Death
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be executed	an and rial-tr	Ë	that initiated events resulting in death) Last Due to (or as a consequence of):									-				
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he de	y the	hysi	1 Yes 2 141 9 Unknown	10	9 Unknowr				,/							
P.O.	been signed by the should be detached	by P	Part II. Other significa	nt conditions o	ontributing to death	but not resul	Iting in the u	nderlying ca	use give	en in Part	1.					cause of death?
ds, quires	en sig ould b	ted									-10	1 🗆	Yes 2	□ No 3 □	Proba	oly 4 Unknown
COT law re	00 01	Completed										24a. Was autor	osy	prior	to comp	y findings available pletion of cause of
Be He	s certificate had director, page 2	Con										1 Tes	rmed?	death	Yes 2	□ No
ital	certifi	Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑	/	Hospital:			🗆	Othe	r. Dea		_				
of V	al this	e: To	27. Manner of Death	10	28a. Date of in	itient 2 E	28b. Time of		c. Injury	at		ne 5 D Resid			ecity)	
on (ath. r: Afte ne fun	icat	2 Accident	Pending Investigation		ay, year)	injury	М	work?	? Yes 2□	No					
Division of Vital Records, alor Attending Physician: The law requires	ter de irecto n by ti	Certificate:	3 Suicide 4 Homicide	6 Could not b determined	28e. Place of ir	njury - At hom etc. (Specify)	ne, farm, stre	et, factory,	office		2	28f. Location (S City or Tow			Rural R	oute Number,
Dital	ours at eral D filled i		07- 0	C- N. C. C. Dhu	sician: To the best of	of south outle	dan dooth o	anurrad at	the time	dete ond	I place on	d due to the er	21120(2) 21	nd manner of	etated	
Division of Vital Records, P.O. Box 6870 To the Hospital or Attending Physician: The law requires that the death certifical	within 24 hours after death. To the Funeral Director: After tompletely filled in by the funer	Medical	(Check 2	Medical Exam	iner: On the basis of se Practitioner: To	examination :	and/or invest	igation, in m	y opinio	n, death or	ccurred at	the time, date a	and place	, and due to the	ne caus	e(s) and manner state
10 th	withir To th сотр	2	29b. Signature and title	e of certifier				29c.	License	number			29d. Dat	te signed (Mo	nth, Da	y, Year)
			MMa	nson				D	00	700	43		SEPT	TEMBE	R	4,2012
	6		DEM A 30. Name and address Robin Ma	of person who	completed cause of	death (Item 2	23a) (Type, P	rint)	+ 0	1.4	105	0.14		a Ma	1.1	1 7170
	Stat	e.	 Date filed (Month, i 	Jay, Year)	32. R 31s	trar's Signatu	ire	317-22	, 36	AIK (- /	Deris A	nore)	7 10	7181 -120
	Registra			EP 0 5 2	2012 100	trar's Signatu	B. A	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 45 A M Physician/ ROSALIE M. HUTTON Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner 4b. City. Town. Balti ivervieu 556X If Under If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Nov. 10,1919 92 VA. **Director** 1 🗆 M 2 🗶 F 220-16-0358 Yrs Usual Residence of Deced show 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County notified at Director 28a-f XX Yes 2 No Baltimore City Baltimore City Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21205 USA 5025 E. Preston St. death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2XXNo Black, White, etc. 5 1 Never Married 2 Married by Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2XX No Specify Specify: er than "natural", the Medical Exam XX Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Mex Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. N/A Factory Worker Factory Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Sarco Pearl Nevinchino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5025 E. Preston St. Baltimore, Md. 21205 Carl Hutton (Son) Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 9-5-2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) a ure of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Hou Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ men disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has performe or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending work? 1 ☐ Yes 2 XNo Natural of thours after death.

Funeral Director: Af the fulletely filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hound to the second to the formula to the formula to the second to the secon 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) a

State Registrar 31. Date filed (M

astern Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Barbara Mezey Heymann Sept 2012 10:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Potomac Montgomery 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday, Days Hours Min Director 152-09-3569 95 1 🗆 M 2 🔀 F April 3,1917 New Jersey Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Examinar mest be notified at filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director Chevy Chase MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 4701 Willard Ave. 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Caucasian 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 end 2 should be filed ment of Heelth end Mental Hy tant: If Item 27 Is marked otl 0 Benjamin Mezey Ilna Kabatchnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20817 Kendra Heymann Sagoff/daughter 6801 Carlynn Court 6801 Carlynn Ct. Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Injury or Depertment of Important: If any injury or once. 4 Donation 5 Other (Specify) Final Journey Crematory 9/7/12 Woodbine, MD 21. Signature of Juneral Service Licensee ^{22. Name and Address of Facility}
Going Home Cremation Service, P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 el-M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of Examine Advanced Age Sequentially list conditions. Examine if any, leading to immediate
rains Enter Indenying
Cause (Disease or injury Due to (or as a consequence of): Failure to Thrive To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use es the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒No
9 ☐ Unknown 4 Pregnant at time of death
9 Unknown 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No Yes 2 XN 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) assisted 2 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner sa stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/4/12 29c. License numbe D0057458 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 M.D. 8218 Wisconsin Ave, Pinky S.Singh, Suite 305 Bethesda, MD 20814 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Michael David Haines 2012 Sept. 02 6:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Director 563-49-2445 1 X M 2 □ F Yrs. Dec. 28, 1960 51 California permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Arch Place, Unit 120 20878 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Server Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Donald P. Haines Glenda Frankeberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Haines / sister Arch Place, Unit 120 Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) inal Journey Crematory 9/6/12 Woodbine, MD 21. Signature of Juneral Service Licensee 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition <u>Metastatic Renal Cancer</u> Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2X No e Hospital or Attending Physician: Th n 24 hours after death. e Funerel Director: After this certificate 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSpice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 9/2/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph 6001 Muncaster Mill Rd Rockville, MD 20855 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:10 AM 2012 Medical Facility Name (if not institution) give street and number Examiner 4c. County of Death N/A Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Hours Country) Director 216-44-0087 1 XM 2 F Yrs 67 July 8,1945 Maryland Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Experimer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1708 Dundalk Ave. Apt. A4 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Truck Driver Seafood Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Everett Hill, Sr. Daisy Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mr. Anthony Hill (Son) 725 Aldworth Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/6/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Signature of Funeral Service Licensee Mark Williams ²Duda≞kuck°funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardiomyolatha schanic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): cate has been signed by the attending physician and pege 2 should be detached for use es the buriel-trensit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No Yes 2 1 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 2 No Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) s efter death. 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours of To the Funeral DI completely filled in Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lan land 31. Date filed (Month, Day, Year) State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 02, Day 2012 Year Jacqueline 1:15 p.M Sue Hard 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 140-38-5014 1 M 2 F 67 Yrs Illinois Dec. 16, 1944 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Rd. 20902 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1XXNever Married 2 ☐ Married Black, White, etc. White If Yes Give 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
National Institute (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Research of Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Cummins Hard Florence Lavene Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Michael Hard (brother) 4453 Quail Run Ln. Sarasota, Florida 34232 20a. Method of Disposition 20b. Place of Disposition (Name of Sept Pate 05. 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Failure Due to (or as a consequence of) Sepsis Due to (or as a consequence of) Pneumonia Due to (or as a consequence of):

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Baltimore, Maryland 21215-0036

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Hospital or Attending Physician: The

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

D63343

29d. Date signed (Month, Day, Year)

09/02/2012

State Registrar Irina Ruban, M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ september 2, 2012 9:00 A M Christina Michelle Heinlein Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Harford Abingdon 239 Kensington Parkway If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 216-92-5543 Maryland 1 🗆 M 2 🕱 F Apr. 21, 1978 34 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 X No Abingdon Maryland Harford 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? 23a USA 21009 239 Kensington Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: "natural" Completed 3 Divorced 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working t of Health and Mental Hygiene.

If item 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bonnie Christine Meadows Jerry Wayne Bilodeau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 239 Kensington Parkway, Abingdon, Maryland 21009 19a. Informant's Name/Relationship (Type, Print) Shawn E. Heinlein Sr. / Husband altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If ii any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Svcs, LLC | 9-5-2012 Bel Air, Maryland Rose Hill 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ERVICAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No that the death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 1 Natural 2 Accident 5 Pending work 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature ar

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cause of death (Item 23a) (Type, Print)

29d. Date signed Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Francis Anthony 4:59 P M Habera August 30 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2012 Elm Street Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 159-30-6114 1 XM 2 F 74 Apr. 8, 1938 Pennsylvania or than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Maryland 1 Yes 2 XNo Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2012 Elm Street 21015 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Journeyman Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental tant: If Item 27 Is marked o ည (nmn) Habera Mary Katherine Zomok Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki L. Brazzon / Daughter 209 Wheaton Lane, Churchville, Maryland 21028 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If I eny Injury or conce. 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn. 9/4/2012 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused shock, or head ailure. List only one cause on each line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARDIDMYOP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burial-transit Cause (Disease or injury Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last led by the attending physician detached for use as the burial Physician/Medical Box 68760° IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 cate has been signated by page 2 should be Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 🗆 Yes 2 🗆 No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Natural injury 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M pleted cause of death (Item 23a) (Type, Print) NORTHAVE

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ co Medical 4a. Facility Named if not institution, give street and r 4b. City, Town, or Location of Death Examiner 4c. County of Death Seasons Hospice Baltimore Randallstown . Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 216-24-4917 1 MM 2 F 83 3/24/29 Maryland or than "naturel", or items 23a or 28a-f show the Wedical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore 1 Yes 2 No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5114 Shelbourne Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Ś 1 Never Married 2 Married 1 Yes Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates. 1952-54 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene, Important if item 27 is marked other than any injury or other traumath. Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winona Seymoure Edgar F. Hynes Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanna Warfield / Daughter Coolpond Court Arbutus, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/1/12 Baltimore, Maryland 21. Signature of Euneral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or co shock, or heart failure. List only pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) umonco Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injuly that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last the attending physicien Physiclan/Medical Box 68760 nse es the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ٥ in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached g Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2€ No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:10A_M Physician/ Thomas Charles Haines 0^{Month} 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Ritchie Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 2 906 all Sacurity Number 3 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/05/1947 Hours Days Min. **Director** 1 🖾 M 2 🗆 F Washington DC 64 Yrs. end Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director N/A Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3812 Hillsdale Rd. 21207 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Newspaper Carrier Sun Paper æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Alice Marie Davis John Haines permit. Pege 1 end 2 should be Department of Health end Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 Hillsdale Rd., Baltimore, MD 21207 Walter Johnson (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State on-site Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June | Service Licensee 227 the second hadres of Back town Jr. Funeral Home PA र । १९ MD 21217 2140 N. Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final Physician/ UNGO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, expired Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Division of Vital Records, P.O. Box sate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Day 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 N Thomas To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of mjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) 30. Name and address of person who or

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUG Herson 01.15AM nnic 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HUSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs, last birthday)
Yrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside Çity Limits Examiner must be notified at Director timore 1 Yes 2 No 9 10e. Street and Number 10g. Citizen of What Country Funeral items 23a trington 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ack Completed 3 ₩Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done duri life. PO NOT use retired) (Specify only highest grade completed) ng most of working O NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) UNK rne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Mumber or Rural Route Number, City or Town, State, Zip Code) Apt. 341, Baltimore, MD 1007 Ariontark 20a. Method of Disposition 20b. Place of Disposition ce hetery, cremato 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence Examiner URINARY TRACT Sequentially list conditions, Examine if any leading to immediat cause. Enter Underlying the burial-transit Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death signed by the attendir d be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PANCREATIC CANCER 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Hospital or Attending Physician; The I.
 24 hours after death.
 Funeral Director; After this certificate h. performed? Yes 2 N 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) AUG 29, 2012 D6662634 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CILUMBIA MD 21.44 10796 MATEEN AWAN HICKIRYRING AD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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			30. Name and address of pers	son who compl	eted cause of de	ath (Item :	23a) (Type, Pri	nt) 3	100	S. Ham	over stee	et,	Ball	hine		_
ソ	Nit To cor		29b. Signature and title of cer		mD	Ho	TELLIATE 9 E	29c. Li	cense nu	mber 674		29d. Da	ate signed	(Month, D	ay, Year) 012 mp 2122	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	(Check 2 Medic only one) 3 Certif	cal Examiner: (ying Nurse Pra	n: To the best of no On the basis of exactitioner: To the	amination	and/or investig	action, in my	opinion, d	death occurred	at the time, date	and place	e, and due	to the caus	se(s) and manner state	ed.
>	F # E C	al Certificate:	3 Suicide 6 Co 4 Homicide de	ould not be termined 2	8e. Place of Injur building, etc.	(Specify)		et, factory, o	ffice		City or To	wп, State	=)		Route Number,	
Division of Vital Records,	ding Phys h. After this funeral di	icate: To	1 Yes 2 W No 27. Manner of Death 1 Natural 5 Pe 2 Accident	2	1 Inpatie 28a. Date of injury (Month, Day,	/ :	ER/Outpatient 28b. Time of Injury		Injury at work?	4 ☐ Nursing	Home 5 Res 28d. Describe					
ʻital	ysician: The is certificate director, pag	m	25. Was case referred to med examiner? 1 ☐ Yes 2 M No.	ical Hosp	ital:				Other:	of Death (Che						
Reco	: The law icate has r, page 2 :	Completed										opsy formed?	pi de	rior to con eath?	sy findings available npletion of cause of	
ords,	requires been sign should be	leted b	on Hospice	CAME		-							-		ably 4 Unknown)
P.O.	es that the dea signed by the a I be detached I	by Phy	9 Unknown Part II. Other significant con			t not resu	ulting in the un	derlying cau	se given	in Part I.	23e. Did	tobacco	use contri	bute to the	e cause of death?	
Box 687	th certific ttending for use as	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		If yes, outcome of 1 Live Birth 24 Pregnant at 9 Unknown	Fetal	death 3	Ectopic pre Other (spec					23d. Date Mor	e of delive	ry Day Year	
092	death certificate be executed ne attending physician and ed for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c	Due to (or as a	conseque	ence of):									
	ted Insit	aminer	Sequentially list conditions, if any, leading to immediate cause fine U. de lying Cause (Disease or injury	b	Due to (or as a	conseque	ence of):									
0	Ph sician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	meta-to Due to (or as a	conseque	Endor ence of):	retra	ص	~61				1	Onset and Death	
			23a. Part 1. Enter the diseas shock, or heart failure. I	e, or complicati	ions that caused										Approximate Interval Between	
Baltir	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Serv	ice Licensee	- CC0	361	esapea 22.	Name and A	Address o	of Facility W	.H. Bac	con	Fune	eral		_
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	yland f shov ed at	ş	10a. State 10b. Co	,			, Town or Loc					,		1	0d. Inside City Limits	
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	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. la	st birthday)	If Under 1	Year It	f Under 24 Hr Hours Min		irth		9. Birthp	lace (State or Foreign	7
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	ith th	ral	10e. Street and Nun 4701 Wil		reniie	#10	13		10f. Zip	815				-	Citizen of N				
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Baltimore,	Page 1 ment of I ant: If its ury or of		1 🕅 Burial 2 l 4 🗌 Donation		3 Removal from	n State	ce	metery, cren Lebar	natory or o	ther place	·		5 ^{te} 2012 -2012	l		•	lew Yor	·k	
alti	permit, Page Department of Important: If any Injury or once.		21. Signature of Fur		**	rd S			. Name an				Danza	<u> </u>				-	
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-	Medical Examiner		resulting in death)	1	Due to	(or as a	conseque	ence of):									,		_
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2	Medical	Check 2		Physician: To the base aminer: On the base Nurse Practitione	isis of exa	amination	and/or invest	igation, in r	ny oninio	n death or	curred at	the time date :	and ntan	and due	to the c	aueale) and m	anner state	d.
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Alan M. Kriegsman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day SEPTEMBER 2, 11:20 P.M 2012 KUTRIK AUGUSTA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE TOWSON MANOR CARE TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 👿 F Yrs MARYLAND /16/1928 213-26-6585 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10b. County 1 ☐ Yes 2 X No TOWSON BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 USA 912 SOUTHWICK DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □XNo Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **OPERATOR** PHONE 12TH_GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HELEN SERBA AUGUST JAGODZINSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GARY JAGODZINSKI/NEPHEW 912 SOUTHWICK DRIVE TOWSON, 20b. Place of Disposition (Name of HOCT PEROSSION POPILES IN 1994) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/7/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) NATL. CEMETERY 21. Signature of Funeral Service Vicensee MOO 1/139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME. P.A. TOWSON, MD 21286 8521 LOCH RAVEN BLVD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Examiner P.O. Box 68760 Records, Division of Vital To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p.

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a or 28a-f shore

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d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2.st Department of Health and Important: If item 27 Is n any injury or other traun once.

Physician /Medical

traumatic event, the Mudical Evannin

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Funeral

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Be Completed by Physician/Medical Examiner

Medical Certification: To

sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

certificate

MD

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	etting 800 ettins to	sease ye II	serse
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown		opic pregnancy or (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ing cause given in Part I.		use contribute to the cause of death?
			24a. Was an autopsy performed? 1 □Yes 240 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical		26. Place of Death (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Home	5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1/2 Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office 28f	f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier	~	29c. License number	29d. Da	te signed (Month, Day, Year)
	Inn	202749		09-03-12

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State Registrar

TRYANT 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# Sperfil, 8931,9/11/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 201 2 ear Sept 7:21a_M Bernadette Kuyawa 4 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 183 Bennett Road Essex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Security Number 5 – 1 4 – 3 0 0 7 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Months (Month, Day, Year) Director 89 1 □ M 2 🕇 F 6/14/1923 28a-f show of Health and Mental Hygiene. Item "natural", or items 23a or 28a-f shooten 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 21221 10e. Street and Number 10g. Citizen of What Country? 183 Bennett Road Funeral USA Was Decedent Ever in U.S. Armed Forces?__ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 ☐ Divorced Specify White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home 8th 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Madeline Kessler ဂ္ Henry Rautt Ruh 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3516 Edwards Lane Baltimore MD 21220 Kendall Barrett permit, Page 1 and 2 Department of Health Important: If Item 2: any Injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
SacredHeartofJesus 9/7/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Funeral Service Licen Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enfer the disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dronare uears Medical resulting in death) to (or as a consiquence of) Examiner 2 weeks neumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine to for as a consecuence off Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav signed by the at Id be detached fo Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 1 No 2 🗌 No 1 Tes To Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide after death.

I Director: Aft
I by the fu 5 Pending M Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🙀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) R118354 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) et Pasadera Point Oak 7900 31. Date filed Month, Day, Year) State Registrar

12-06017 Kwang Seok Kim

	1- For State Certificate of Death Reg. No.										
Physiciar Medical Examin	11	Decedent's Name (First, Midd		wang Seok	Kim				2. Date of Dea Month August 11	Day Year	3. Time of Death 0910 hrs
		4a. Facility Name (if not institution Edwards Ferry Boat F				Poo	r, Town, or I Isville	Location of Dea		4c. County of D Montgome	ry
Funeral Director		5. Social Security Number 224-81-0843	6. Sex		rs. last birthday	Yrs.	iths Days				Birthplace (State or
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiente. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	erai Director	Usual Residence of Decedent 10a. State VA Pril 10e. Street and Number 6817 Hollow Glen (11. Marital Status 1 Never Married 2 M	12. Was I	Decedent Ever in		10f. Z Was Dece	ip Code	Gainesville 20155 Danic Origin? (S	Specify Yes or No		th Korea
1036 vithin 72 hours after re than "natural", o Medical Examiner 1	mpleted by	15. Decedent's Education (Spec Elementary/Secondary (0-12) unkn.	College	Year	1 16a. Dece	dent's Usua most of w	orking life.	specify: on (Give kind of DD NDT use re t Work		Specify:	Asian ass/Industry N/A
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	20	17. Father's Name (First, Middle,	Unl	kn.						Maiden Surname) Unkn.	
MD 21 nd 2 should uith and Me m 27 is ma aumatic cy	L	19a. Informant's Name/Relations Taehee Kim / Daug			681	7 Hollo	w Glen	Court, Ga	inesville, V		
Baltimore, ML permit. Pages 1 and 2 s Department of Health at Important: If item 2/t injury or other traum:		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp. 21. Signature of Funeral Service	ecify:		Db. Place of Dis crematory or Chesape	other plac	e) ematory	9,	Date /2/2012	20c. Location - City Belts	ville, MD
		Dorota Marshall	Doub 4	Lucy Louised the de	usll	Maryla	ind Crei	mation Ser			more, MD 21203
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <mark>Drowning</mark>			i the mode	or dying, a		or respiratory and	sat, shock, or near	Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	s a consequenc				· · · · · · · · · · · · · · · · · · ·			_
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J. Box 68760, the death certificate be by the attending physici whed for use as the buring death.		3b. Was decedent pregnant in th past 12 months?	e 1 Live	e birth gnant at time of known	2 🗌	Fetal death Other (Sp	_	Ectopic pregn	ancy	Month	Day Year
P.C es that igned be deta	<u> </u>	Part II. Other significant conditi	1 Yes 24a. Was a	2 No 3 F	o to the cause of death? Probably 4 Unknown autopsy findings available to completion of cause of						
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f Vital Physician: or this certif	2 L	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatie		DOA C	Other Nursi	ng Home 5	Residence 6 🗸 0	ther: Scene
sion o ttending death. ctor: Afture y the fune		1 Natural 5 Pend	ing FOUN tigation Aug 1	te of Injury oth, Day,Year) ID: 1, 2012	FOUND: 0845 hrs			es 2 🗸 No		now injury occurred vned himself	
Division of V To the Hopital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of		4 Homicide deter	I not be	ace of Injury - A	t home, farm, st	reet, factor	y, office bu	ilding, etc.	or Town, S		Rural Route Number, City esville, MD
To the Howithin 24 h To the Funcompletely		2 Medical Exar	niner:On the bas and manne	s of examination						e(s) and manner as s and place, and due to	
	2	9b. Signature and title of certifie	(1, m1)			29	O.C.M			29d. Date signed (August 12, 20	
	3	0. Name and address of person Pamela E. Southall, M	•	use of death (It t Medical Ex	,	00 W. B	altimore	Street, Balt	imore, MD 21	1223	
Stat Registra		SEP 0 5 2012"	Servera .	Registrar's Sign	ature				·		

12-0641	2
Krishna	Khatri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 28116 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ate of Deat	h	,,,	eg. No.	
Physici ledical Exam		Krishr	na Khatri			2. Date of Deat Month August 25	Day Year , 2012	3. Time of Death 1010 hrs
		 Facility Name (if not institution, give street and number) Silopanna Road)	4b. City, 1 Anna	own, or Location of D polis	eath	4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Ag Usual Residence of Decedent	ge (In yrs. last bir	rthday) If Unde Month Yrs.	or 1 Year If Under 2 s Days Hours	Min.	Foreig	thplace (State or in untryNepal
w any		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
ryland a-f shov t ooce.	ctor	MD Anne Arundel	<u></u>	10f. Zip	Annapo		ng. Citizen of What Cour	1 Yes 2 No
ith the Ma 23a or 28 notified a	al Director	20 Silopanna Road, Apt. 17	15		21403		Ne	epal
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Inspertment of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic eveot, the Medical Examiner must be notified at socs.	Funeral	1 Never Married 2 Married Armed Forces		If Yes, specif	nt of Hispanic Origin? y Cuban, Mexican, Pu X No specify:		White, etc.	Asian
tours aft	ed by	15. Decedent's Education (Specify only highest grade cor	npleted) 16a.	Decedent's Usual	Occupation (Give kind king life. DO NOT use		16b. Kind of Business/I	
1036 Aithin 72 han ene.	Completed by	Elementary/Secondary (0-12) College (1-4 or 12	5+)		Did Not Work	retiredy	Ν	J/A
215-0 e filed v tal Hygi ked oth ot, the l	Be Co	17. Father's Name (First, Middle, Last) Hanveer Kha	tri		18.Mother's N	lame (First, Middle, M K	laiden Surname) usuri Khatri	
21; hould b nd Men is mar	70	19a. Informant's Name/Relationship (Type, Print)	19			or Rural Route Num	ber, City or Town, State,	Zip Code)
and 2 s and 2 s fealth a item 27 traum		Laxman KC / Nephew 20a. Method of Disposition	20b. Place	of Disposition (Nan		7, Annapolis,	MD 21403 20c. Location - City or	Town, State
Baltimore, MD 21215-0036 etmit. Pages I and 2 should be filed within 7 bepartment of Filed and Mental Hygieria. In teem 27 is marked other than injury or other traumatic evect, the Medical		1 Burial 2 Cremation 3 Removal from St. 4 Donation 5 Other Specify:	ate	tory or other place) tlantic Crema		9/9/2012	Glen Bu	rnie, MD
Balti permit. Departr Import injury		21. Signature of Funeral Service Licensee Dorota Marshall	Laushal	1	Address of Facility Id Cremation S	ervices, PO B	ox 1413Baltimo	re. MD 21203
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do no					Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Asphyxia by hat Due to (or as a conse						Death
	ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):		<u> </u>			
AK = is	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	equence of):					
760, for its property of the purial - transit	Medical E	d.						
3760, ificate be g physici		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcor			3 Ectopic pre	anancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending of	Physician	past 12 months?	time of death				Nondi	ay real
ires that the designed by the signed by the sibne detached for	ğ	Part II. Other significant conditions contributing to death	n but not resulting	g in the underlying	cause given in Part I.		pacco use contribute to t	
ords, w require s been si should b	Completed					24a. Was a autops	n 24b. Were aut	opsy findings available ompletion of cause of
tal Records cian: The law requi certificate has been ector, page 2 should	Com				_	perform 1 Yes 2	ned? death? ✓ No 1 Yes	s 2 No
Vital ysician his certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 ER/Ou		6.Place of Death (Che		Residence 6 🗸 Other:	Scene
Division of Vital Records, tal or Atteoding Physician: The law requirers after cleath. al Director: After this certificate has been sited in by the funeral director, page 2 should be	\vdash	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju FOUND: FOUND:	FOU	JND:	8c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe he Subject hang	ow injury occurred ged self	
Division Hospital or Atteod 24 hours after death Fuoeral Director:	Certification:	Suicide o Codid Hot be		arm, street, factory,	office building, etc.	or Town, Sta	reet and Number or Rur ate) Road, Annapolis, MD	al Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Atteoding Physician: The law requires that the death certifi within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Medical C	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of example of the control of t				and due to the cause	(s) and manner as state	
T. wij.	Me	29b. Signature and title of certifier	1	29c.	License number		29d. Date signed (Mon.	th, Day, Year)
9		30. Name and address of person who completed cause of di	Peath (Item 222)	2	O.C.M.E.		August 26, 2012	
2		Zabiullah Ali, M.D. Assistant Medical Ex	caminer 90	0 W. Baltimore	Street, Baltimo	re, MD 21223		
St Regist		31. Date filed (Month, Day, Year) 32. Registrar	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22^{Day} 0^{Month} Physician/ THERESA M. KIRCHNER 2012 6:10 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Sykesville Fairhaven Nursing Home Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 219 16 9263 **Director** 1 🗆 M 2 🔀 F 03 14 1925 Maryland 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 No Sykesville MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21784 611 Fern Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Blue Cross -Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Blue Shield 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည Louis C. Kirchner Mary R. Vitek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 591 Noland Dr Sykesville, MD Steven Cadogan - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 8/27/12 Baltimore, MD Holy Redeemer Cem 4 Donation 5 Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122 Signature of Signature Licensee 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Recita Canco years disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes _ 2 🗌 No 1 ☐ Yes 2 🗷 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 - Residence 6 - Other (Specify) ျ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural injury 5 Pending Investigation Accident Suicide 6 🖂 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012 5

Mam lan MD

Day, Year)

SEP 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ilius Henry Lin	ick	State of Maryland / Department of Certificate of Ce		2	12 2811
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	n Bodin .	Reg. No. 2. Date of Death	3. Time of Death
ledical Exami		Julius Henry Linck		Month Day Year August 29, 2012	1607 nrs
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Deatl Baltimore	n 4c. County of	Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir	→ ` 1	Foreign
Director	1	224-05-2798 1XM 2 F 91 Y		Sept. 15, 1920	Country) Virginia
ń u		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation		10d. Inside City Limits
how a	ı.	Maryland Anne Arundel	Crofton		1 Yes 2 X No
larylar 28a-fs at on	ecto	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	t Country?
the N	Dir	1481 Crofton Parkway	21114	United	States
th with	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		American Indian, Black, etc.
er dear	Fur	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2[X] No specify:	Specify:	TT 1.
urs aft tural" amine	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of	work done 16b. Kind of Busi	White ness/Industry
5 72 ho na "na	lete	Elementary/Secondary (0-12) College (1-4 or 5+) during to	most of working life. DO NOT use ret	ired)	
within iene.	dmo	12	Orthotist	Medic	eal
15-(filed al Hyg	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
21215-0036 und be filed within 7 Mental Hygiene. marked other than	o B	Julius H. Linck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Lucy H		State, Zip Code)
MD and 2 sho alth and 2 in 27 is	'		Corkberry Lane A		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be little within 72 hours after death with the Maryland Departient of Health and Mental Higgiene. Important: If time 27 is marked other than "natural", ur items 23a or 28a-f show any injury ur other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 2 X Cremation 3 Removal from State 2.2 Removal from State	City or Town, State		
Baltimore, permit. Pages 1 ar Department of Hea Important: If ite		4 Donation 5 Other Specify: W. Arund	el Crematory 2	ot. 1, 2012 Odent	on, Maryland
Balt Depart Impor		bloom of the Alat not	Name and Address of Facility Donaldson Funeral	Home & Cremato	ry, P.A.
Physician		23a. Par I. Enter the disease, or complications that caused the death. Do not enter	1411 Annapolis Rothe mode of dying, such as cardiac of	oad Odenton, Mar or respiratory arrest, shock, or hear	Approximate Interval
/Medical Examiner		fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and Death
		b			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
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executed an and al - transit	edical Examiner	d			
be ex	edic	UNPENDED AMENDED	41.1 (41.1)		
Box 68760, ne death certificate be the attending physicine for use as the burn	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregna	ancy 23d. Date of do	elivery Day Year
Box 6876 death certificate the attending phy	Physician/M	4 Pregnant at time of death 5 C	Other (Specify)		
by the chefiched f	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribu	ute to the cause of death?
ires that the signed by d be detach	d by			1 Yes 2 No 3	Probably 4 Unknown
of Vital Records, ag Physician: The law requir this certificate has been someral director, page 2 should	Completed				ere autopsy findings available or to completion of cause of
I of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	шо			performed? de	ath? ✓ Yes 2 No
al R	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)	
Vit	To E	1 Yes 2 No Inpatient 2 FR/Outpatier			Other:
- = . ^ 4		27. Manner of Death 28a. Date of Injury 28b. Time of Month. Day Year) 1 Natural 5 Pending Aug 29, 2012 1428 hrs	Injury 28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject shot self	i
Division tal or Attendiu ts after death. al Director: A	icati	2 Accident Investigation 28e Place of Injury - At home, farm, stre		28f. Location (Street and Number	or Rural Route Number. City
Divi	Certification:	3 V Suicide 6 Could not be determined (Specify) Single Family Home	,,,	or Town, State) 1481 Crofton Parkway, Crofton	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place, and	I due to the cause(s) and manner a	s stated.
To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.			
LVE	×	29b. Signature and title of certifier	29c. License number		(Month, Day, Year)
		After Brasself. MD	O.C.M.E.	August 30, 2	.0 12
1		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	V. Baltimore Street. Baltimo	ore, MD 21223	
S	tate				
Regis		31. Date filed (Month, Day, Year) 2 September 32. Registrar's gnature			

DHMH 17 Rev 1/2001

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:00 A M 2012 Donald Frederick Lincoln August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rising Sun 1839 Biggs Highway Cecil 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min. Hours (Month, Day, Year) **Director** 215-32-5703 1 🛛 M 2 🗆 F Yrs 76 01/03/1936 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1839 Biggs Highway 21911 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 \square Never Married 2 $mathbb{k}$ Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Truck Driver Construction Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown F. Lincoln 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Biggs Highway, Rising Sun, MD 21911 <u> Victoria Lincoln / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry | 08/22/2012 | Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final plastic Onset and Death Physician/ elodip disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 No Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other 2 No ျပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2012 D0054084 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 W. High Street, Ste. 104, Elkton, MD 21921 Jamil Khatri, 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-201

Registrar

SEP 0 5 2012

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Alan Robert Lovesee September 2012 0850 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 576 College Parkway Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 402-66-1288 63 Director 1 M 2 □ F Feb 27, 1949 Florida 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Rockville 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 576 College Parkway 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Congressional Elementary/Secondary (0-12) College (1-4 or 5+) Lawyer/Lobbyist Relátions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Lovesee Adah Elizabeth Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Rose Ann Lovesee/wife 576 College Parkway Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 09/06/12 Woodbine, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Metastatic Colon Cancer disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Tijury that initiated events Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.
To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (estale D33443 September 4, 2012 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Sevenlock Rd. Rockville, MD 20854 Alan Pollack, M.D. 31. Date filed (Month, Day, "Year) 32. R State Registrar

12-06398

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brandon Logan State of Maryland / Department of Health and Mental Hygiene 2012 28121 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 25, 2012 Medical Examiner Logan 0004 hrs St.Laurent Brandon 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 100 Blk. of Rt. 222 Port Deposit 8. Date of Birth (MM/DD/YYYY) 9, Birthplace (State or 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Foreign Months Hours Min Director 77 08 01 1X M 2 F 35 Country) 237-27-6403 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits iny Baltimore 1 Yes 2 No MD 28a-f show hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 523 Mt. Holly Street 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: Black <u>م</u> 16b. Kind of Business/Industry Coraluzzo Petroleum 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.
ant: If item 27 is marked other than "
ar other traumatic event, the Medical I Truck Driver 12th grade na Transporters 18.Mother's Name (First, Middle, Maiden Surname) Felicia Shearod 17. Father's Name (First, Middle, Last) Phillip Logan Sr. 19a, Informant's Name/Relationship (Type, Print) Phillip Logan Sr.-Father 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State Date timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/1/2012 Goldsboro, NC old Mill 4 Donation 5 Other Specify. 21. Signaure of Funeral Service Licensee 22 Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, 21215 Part I. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical g physician a s the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy use as t Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ficate has been signed by the page 2 should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 헏 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA this 1 Yes 2 No After 28b. Time of Injury 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject driver of propane tanker in Aug 24, 2012 Division 1 Natural 1 ✓ Yes 2 No filled in by the fi 5 Pending 24 hours after death: Funeral Director: collision/explosion 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 100 Blk, of Rt. 222, Port Deposit, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 25, 2012 30. Name and address of person who completed suse of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 900 W. Baltimpre Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SFP 05 Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 2012 HOUKUN LU P^{M} 9:44 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 08/24/1924 Country) China Director 578-15-2057 1 □ M 2 1 F 88 permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macked Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 Rollins Avenue # 533 20852 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2x No Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 √ Widowed 4 □ Divorced Year or Dates Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ Editor Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guofan Lu Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank X. Wang / Son 1 Avian Drive, East Greenbush, NY 12061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once. 4 Donation 5 Other (Specify) Chesapeake Crematory 9/11/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility)ouela Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Stoke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): e Hospital or Attending Physician: The lew requires that the death certificete be executed after death.

Funeral Director: After this continued. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2/20 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c ertifie 29c. License number 29d. Date signed (Month. Day, Year) D43091 9.3-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 801 1ou Levid 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 5 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0005AM 012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA tal Da Itymure ci 20 1 hours 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 3302 (Month, Day, Year) Director 1 □ M 2 💆 F 56 JAN 24 1956 Usual Residence of Decedent permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. In the machine importent: If item 27 is marked other then "neturel", or iteme 23e or 28e-f ehow environger of their treumatic event, the Medical Examinar must be notified at once. Director 10c. City, Town or Location 10d. Inside City Limits MD BAltiMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 12. Was Decedent Ever in U.S. Armed Forces ↑

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced BIK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry cify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4 or 5+) SpecialisT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ATHERINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) THINITY Cemetery BAHO. Md. 21. Signature of Funeral Service Linear neral Service: P.A. 2 Fres 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysiciani RPSIZ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ollishste Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hoopitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director has a 2 should he death. Cause (Disease of Injuly troperturea that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No 4 Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown)iabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 2 No 1 ☐ Yes 2 ☐VÑo ı ∏ Yes 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 No မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sign 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR nai State

DHMH 17 Rev 06-2011

Registrar

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			FOR	State of Marylan					∕lental Hyg	giene	012	20	121.
			State Registrar		Cer	tificate	of D	eatn		Reg. No.	UIZ		-
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	Medic	al	Bernard McNaughto			li ou	- 1	ite e of Death	August		unty of Death		<u>b</u>
	Examin	eı	a. Facility Name (if not institution, give str			Lau		ocation of Death			nce Ge		
			9258 Cherry Lane, # 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	et hirthday)	_If Under		If Under 24 Hrs.	8. Date of Birt		9. Birth	place (State or	Foreign
	Funeral Director		, occidi cocarri, rranna		37 Yrs.	Months	Days	Hours Min.	(Month, Day	, Year)		ntry) 1esota	
-			Usual Residence of Decedent		110.				May 2,	1923	MITTI		
	and shov	٥	10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City	
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	a or a	Funeral Director	10e. Street and Number			10f. Zip				J	of What Cou	untry?	
	is 23	ner	9258 Cherry Lane,				708	spanic Origin? (Sp	anifu Van ar No	USA	Race - Ameri	isan Indian	
	deatl riten	교	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S Armed Forces?	5. 13.	lf Yes, spec	ify Cubar	n, Mexican, Puerto	Rican, etc.)		Black, White		
36	after	d by	3×2×Widowed 4 Divorced	₩X Yes 2 □ No If Yes, Give Year or Dates.		1 Yes	2 🔀 No	Specify:		Spe	ecify: Wh	nite	
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pu	filed al Hy d oth		17. Father's Name (First, Middle, Last)				l	18. Mother's Nan Lillian		Maiden Surr	ia <i>m</i> e)		
ylai	ld be Ment arker atic e	임	Charles L. McNaug	inton							C	0. (.)	
Maryland	shou and is m		19a. Informant's Name/Relationship (Type					nd Number or Ru					0016
2	Ind 2 lealth im 27 her tr		Gloria Ferraiuolo/	step-daughte:	r 1523 Place of Disp	1 Roy	al C	rest Dr.	, Apt.	LOZ, H	aymark tion - City or	Town, State	2016
Ore	ye 1a t of H If ite or ot	1	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R	amount from State	emetery, cre	matory or o	other place	e) Sep	t. 6,		sville		
ţį	t. Pag tmen tant: jury		4 Donation 5 Other (Specify)		verer	alls C		is of Facility DO	012 naldson				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	MO	1053	313 1	'albo	tt Ave.,	Laurel	, MD 2	0707		
	-		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the deat	h. Do not en	ter the mod	de of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Bety	ween
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	n ii	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								
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09/	physi			d									
6876	entific ding se as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn	ancy					230	d. Date of de	livery	
Вох	death o	cial	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fet 4 Pregnant at time of	al death 3 death 5	Other (s	pregnanc pecify)	;y			Month	Day `	Year
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P.0	law requires that the nas been signed by the e 2 should be detach	N V	Part II. Other significant conditions cor		sulting in the	underlying	cause giv	ven in Part I.	2	, _		the cause of d	
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0.0	w req s bee 2 sho	Completed	A Lib						24a. Was		24b. Were au prior to	topsy findings completion of c	available ause of
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a	ysician: T s certifica director, p	Be C	25. Was case referred to medical examiner?				26. P	lace of Death (Che					
Σ	Physical this ceral direction	2	1 Yes 2 No	lospital: 1 Inpatient 2				4 L Nursing	Home 5 Res			cify)	
of	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time injury		28c. Injur work	ζ?	28d. Describe	how injury o	ccurred		
ion	Attending Physician: or death. ector: After this certific by the funeral director,	iji	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ama farm s	M troot facto		Yes 2 No	28f Location	(Street and N	Jumber or Ru	ıral Route Numi	ber,
Division of Vital Records,	- E E	Certificate:	4 Homicide determined	building, etc. (Speci	fy)	stroot, racto	y, omoo		City or To	wn, State)			
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	To the Hos within 24 hd To the Fun-	Ž	only one) 3 L Certifying Nurse	e Practitioner: 10 the best of	my knowleds			e number	place, and due to		signed (Mont		
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			30. Name and address of person who co	1		Print)		-434	/ /				
5-1	1		30. Name and address of person who co	ompleted cause of death (Ite	MBP	000	17	HmB.	CAR	EC	TR,	FT. ME	MOE
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature							MESE	753
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28125 Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Date . Month Day 3 **Physician** 3:30PM Mannin Cintonia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3 unit Mars B2H, ner Holter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 1 □ M 2 F Months Days Hours 90Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 X No Funeral Director White Marsh MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21162 11315 Holter Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 21K No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Lanham ပ Edward Krantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11315 Holter Road White Marsh, Maryland 21162 Jennifer Canapp (Granddaughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/4/2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Servic Icense Far1 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Fundra 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease shock, or heart failure. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Betwe nset and Death Immediate Cause (Final SOSTOINE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗌 No 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the should be detached certificate has b irector, page 2 sl funeral director, After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu filled in by the

Division of Vital Records, P.O. Box 68760,

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

item 27

= 5

Department o Important: If any injury or once.

Physician

/Medical

Examiner

physician and s the burial-trans

attending p

Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or itel

Baltimore, Maryland 21215-0036

State Registrar

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Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NoncyBen

9101 Franklin

dress of person who completed cause of death (Item 23a) (Type, Print)

Nancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28126 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2 Tokiko Watanabe Monteith 2012 0849 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9113 Sumner Grove Drive Prince George's Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. Dec 20, 1926 Director 502-56-6420 1 M 2 X F 85 Japan Usual Residence of Dece or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director DE Sussex Bridgeville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19933 58 Whistling Duck Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give 14. Race - American Indian ģ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Civil Servant Federal Government Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Kurazo Watanabe Misao Tamada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to William F. Monteith/husband 58 Whistling Duck Drive Bridgeville, DE 19933 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 09/05/2012 Woodbine, MD 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Malignant Neoplasm of bronchus and lung years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated so or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed death? Yes 2 X No 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) daughter's Hospital Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 ☐ Accident 3 ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) AC000937 September 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melanie Reynolds ANP-BC 1801 McCormick Dr. #180 Largo, MD 20774 Registrar

12-06504

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December Name (First, Medial. All) December	Oneida M. Mackle	•	State - For State Registrar	of Maryland /	Department of Certificate of			Mental H		2 (Reg. No.	12 2	181
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The dical Examiner Takine. List only one cause on each line. The dical Examiner The	Baltimore, MC permit. Pages I and 2 s Department of Health a Important: If item 21 injury or other fraum	-	20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Removal from Stat	20b. Place of Dispo crematory or of Final Jou	sition (Name ther place) arney Name and A	of cemet	ery, atory (Facility Cremati	Date 09/04/12 on Serv	2 Woodbin	e, MD Box 78	4
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29b. Signature and title of certifier 29c. License number O.C.M.E. August 30, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD. Assistant Medical Examiner 31. Date filed (Monte Pr.) Years 32. degistrar's Signature 33. Date filed (Monte Pr.) Years 34. Date signed (Monte, Day, Years) 29d. Date signed (Month, Day, Years)	Divi e Hospital or 1.24 hours afte e Funeral Div		4 Homicide determined	(Specify) Sing	ile Family Home	rred at the ti	me, date	and place, and	or Town, 11428 Crysta I due to the cau	State) at Falls , Smithsb use(s) and manner a	urg, MD	
Melissa Brassell, MD_ Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Monorphy) Years 2012 32 registrar's Signature	To the compl		29b. Signature and title of certifier	and manner stated.		29c. l	_icense n	umber	at the time, date	29d. Date signed	(Month, Day, Yea	ar)
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É	To the Hospital or Attending Physician: The law requires that the within 42 hours after death, within 42 hours after death, To the Funeral Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach.			Ta							1	City or Town			
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12-06524 Bobbie McNeill, Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 28129

	1- For State RegIstrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death																
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MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. a 27 is marked other than numatic event, the Medical To Be Comple				ship (Type, Print		er	40						al Route Nu		•		
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To the Hospital within 24 hours To the Funeral completely filled	one)		Medical Exa	miner: On the ba	asis of exami ner stated.	ination an	d/or inve	stigation	n, in my	opinion	, death occ	curred at th	ne time, date	and pl	ace, and du	e to the	cause(s)
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State Registrar																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} MINOR AUG 30 2012 11:31 VIVIAN CATHERINE Medical 4a. Facility Name (if not institution, give street and number) WALTER REED 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL MILITARY MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 6. Sex (Month, Day, Year) Months Days Hours Min. Director 434-50-5608 1 🗆 M 2 😾 F 3-7-32 Louisian ^a 80 Page 1 and 2 should be filed within a more than the Hygiene. Innert of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show tant: If item 27 is marked other than "natural", or items 23a or 28a-f show that: If item Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a, State Director Va. Arlington 1 Yes 2 No Arlington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1728 S. Oakland Street 22204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4x Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Joseph Eloise Gipson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 S.Oakland St.Arlington, Va. 22204 Sandra Holmes-Daughter Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/2/12 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) MetropolitanCrematory Alexandria,Va 22. Name and Address of Facility Chinn Funeral Service Signature of Funeral Service Licensee Robert 2605 S.Shirlington Rd.Arl.Va.22206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IE FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (specify) ed by the a detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed | page 2 should be det Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 ☐ Yes 2 🔯 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA မ 24 hours after death.
Funeral Director: After this etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 2 Accident 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifications and signature and title of certifications. 29d. Date signed (Month, Day, Year) 0101247743 31AU62012 30. Name and address of person who completed cause of death (Item 23a) (Type, PrintWALTER REED NATIONAL MILITARY MEDICAL CENTER ROBERT J. WALTER, BETHESDA, MD 20889 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

SEP 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 201 3:35 PM August 29, Mirta T. Mulhare Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury Methodist Village Gaithersburg Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Y Oct 03, If Under 1 Year If Under 24 Hrs. 7, Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** ^{Year)}1930 Days 1 M 2 X F Months Hours 81 Yrs Cuntry) Cuba Director 047-28-2941 Usual Residence of Decedent shov aţ 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 No Montgomery Gaithersburg 5 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 20877 301 Russell Avenue United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. o. þ 1 Never Married 2 Married 2 No 1 Yes 3altimore, Maryland 21215-0036 1 Syes 2 □ No Specify "natural", Completed 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates Cuban 16a. Decedent's Usual Occupation
'Give kind of work done during most of working the Medical Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) 5+ Elementary/Seconday (0-12) State Univ. of NY Animal Researcher traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gabriel De la Torre Zoila Castrione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Joanna Boales /Daughter 7106 Moorland Drive Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 Cremation 3 🗆 Removal from State 31 Aug Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ackinsonism Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause (Disease or linjury Due to for as a consequence of a Examir and -transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Year Pregnant at time of death the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page death? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Many r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. Natural iniury work? 5 Pending 2 🗌 No thin 24 hours after death.

the Funeral Director: A
mpleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

100

29b. Signature and title of

30. Name and address of person Teven

31. Date filed (Month, Day, Year)

ompleted cause of death (Item 23a) (Type

Olinsi

License number

29d. Date signed (Month. Day, Year)

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide	6 ∐ Could determ			of Injury - At g, etc. <i>(</i> Spe	t home, farm, s cify)	treet, factor	, office			28f. Location (8 City or Tov			or Rural	Route Numb	er,
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12-06271 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kevin McNeary 2012 28133 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Month August 20, 2012 1253 hrs **Medical Examiner** Kevin McNeary 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death N/A **Baltimore** St. Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Days Director 08/03/1963 Country) DC 48- 49 Yrs. 577-82-7202 1 M 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Baltimore MD N/A permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 4366 Parkton St. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married Yes 2 X No Black 1 Yes 2 No specify: 3 Widowed If Yes, Give Year Specify: Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Russell Toyota Body Shop Foreman 11th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Kirkland Rudolph McNeary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4366 Parkton St., Baltimore, MD 21229 Sharon McNeary(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Burial 2 X Cremation 3 Removal from State Baltimore, MD on-site Crematory Donation 5 Other Specify Funeral Home PA Signature of Funeral Service L/C 227 to recognize the of Barriown JŔ. 1 2140 N. Fulton' Ave., Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line een Onset and /Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED X AMENDED physician the burial -#7perFH,G931,9/10/2012,WS Records, P.O. Box 68760, The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Year Day ed by the attending detached for use as t Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performe death? page Yes 2 ✔ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) of Vital BB examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Subject hanged self Certification Natural Division FOUND: 1 Yes 2 ✔ No Pending death the Aug 20, 2012 1030 hrs Accident Investigation within 24 hours after de To the Funeral Direct completely filled in by filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State)
4366 Parkton Street, Baltimore, MD determined (Specify) residece Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State Registra

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

Registrar's Signaty

ORIGINAL

parka

29c License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

August 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Marshall Awaust Physician/ 2 year Medical 4c. County of Death N/A **Facility Name** (if not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 219-90-5388 Months Director 1**X** M 2 □ F Maryland 04/17/1958 54 ?7 ie merked other then "neturel", or items 23e or 28e-f ehow treumetic event, ir e Medical Examinar must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Pege 1 end 2 should be filed within 72 hours efter death with the Merylend Director 1X Yes 2 ☐ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? $U \bullet S \bullet A \bullet$ Funeral 21213 1418 N. Bethel St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) i Hyglene. other then " Elementary/Secondary (0-12) 2 vears College (1-4 or 5+) Solo Cup Co. Mechanic years Be 18. Mother's Name (First, Middle, Maiden Surname)
Delores Summerfield 17. Father's Name (First, Middle, Last) Heeith end Mentei မ Charlie McCray Marshall Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 5710 The Alameda Apt A, Baltimore, MD21239 Lakeysha Marshall (daughter) other t Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of Importent: If it eny injury or o ᇹ cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State KIng Mem Park Cemi09/12/12 |Baltimore,MD 4 Donation 5 Other (Specify) Jr. Funeral Home PA 21. Signature of Funeral Service Licenses 27. dagseaphiddhes aBrodwn Baltimore, MD 21217 2140 N. FUlton Ave., 23a. Part 1. Enter Trock, or I ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest and failure. List only one cause on each line. Approximate Interval Between Diabetes Onset and Death e (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Exam Hospitei or Attending Physicien: The lew requires thet the deeth certificate be executed To the Hospital or Attanding Physician: The law requires that the death cartificate be execute within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-tren that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 🗌 No 1 Inpatient 2 K ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifie 29b. Signature at 29d. Date signed (Month, Day, Year) D006825

Registrar
DHMH 17 Rev 06-2011

State

CR.

31. Date filed (Month, Day, Year)

5

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** September 19125 PM 2012 Diana Martin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 26, 1956 9. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F 216-72-2694 55 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show at Baltimore Dundalk MD 1 ☐ Yes 2 X No Director Examiner must be notified 10f. Zip-Code 21222 10g. Citizen of What Country? with ō 1701 Holaview Rd. Apt. C2 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 14. Race - American Indian, Black White, et Black Specify: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2X No ģ 3 Widowed 4 Divorced Year or Dates "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Medical Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) N/A 12th N/A . Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Oliver Charles J. Martin, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once, John Alston/ Husband 1701 Holaview Rd C2 Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory 9/8/12 Catonsville, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility Beverly D. Cror 2700 Edmondson Ave. Balto., uneral Service Licen Cromartie F/S Signatur Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1 the disease. or heart failure. List only one cause on each line Immediate Cause (Final **Physician** SCVD disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events and physician an resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 ¥Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 1 Yes 2 💢 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Josphan.

4 hours after death.

Funeral Director: After this ce 1 XYes 2 □ No 2 KER/Outpatient 3 □ DOA မ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3
Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Carlisle 31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rile of cert

29b. Signature and

anily

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

ptember 1,2012

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ Norman 2012 445 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death allstown Baltimore ttosp; 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 1 M 2 M F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No timore 10e. Street and Number 10g. Citizen of What Country? Funeral ala Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates 1 Yes 2 No 3 Widowed 4 ☐ Divorced Slar 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during te. DO NOT use retired) (Specify only highest grade completed) ndary (0-12) College (1-4 or 5+) omes Be 17. Father's Name (First, Middle, Last) er's Name (First, Mid e, Maiden Surname) ဨ lohasor 19a. Informant's Name/Relationship (Type, 19b. Mailing MD 21227 ole 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Ligense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Physician/ actic disease or condition resulting in death) Medical Due to (or as a consequence of): [']Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 After this certificate has been signed by the attending funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No Obstructive Pulmonam 24a. Was an autopsy 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 1 No Hospital ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred vithin 24 hours after co...
To the Funeral Director: After 1 Natural 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Sigr 29c. License number 29d. Date signed (Month. Day, Year) D0053337 e where a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard Suite N-R Glen Seay 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Division of Vital

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 2 1 - For State Registrar 28137 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5:35 AM 20 Orman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1922 E. Preston Street N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 11/27/1934 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 - F 77 Country) 240-48-8840 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1922 E. Preston Street 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th N/A Construction Various Employers 18. Mother's Name (First, Middle, Maiden Surname)

ESTELLE Thompson 17. Father's Name (First, Middle, Last) Lewis Norman Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Pinckney-Neice 15 Taft St. Stratford Conn. 06615

	ns s	9	1922 E. Pleston Street		212	213			USA		
	deat iten nerr	Fune	11. Marital Status 12. Was Decedent Ever	in U.S.	13. Was Decedent of Hi	ispanic Origin? (Specit ın, Mexican, Puerto Ri	y Yes or No- can. etc.)	1	4. Race - Ame		
36	alle: ", or xami	d by	1 X Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 💢 No		,,		Black, White Black, Black, Black, White Blac		
8	ours atura	etec	3 Wildowed 4 Divorced Year or Dates.	140							_
5	72 h n "na Aedio	Completed	(Specify only highest grade completed)	(Decedent's Usual Occup: (Give kind of work done a life. DO NOT use retired)			16b. Kir	d of Business	Industry	
212	within giene. ner tha t, the N		Elementary/Seconday (0-12) College (1-4 or 5+) 10th N/A		Constructi	on		Var:	ious E	Employers	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medical Examiner mus once.	To Be	17. Father's Name (<i>First, Middl</i> e, <i>Last)</i> Lewis Norman			18 Mother's Name (i	First, Middle, Thom	Maiden S	umame)		
ary	hould and M s mai umat		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street a					in Code)	
Σ	nd 2 sl ealth a n 27 i		Beatrice Pinckney-Neice		Taft St.					<i>p</i> 0000,	
ore	e1ar ofHe officer		20a. Method of Disposition 2 ☐ Removal from State 2	0b. Place of	Disposition (Name of crematory or other place	e) Da	te	20c. Loc	ation - City o	r Town, State	
<u>.</u>	. Pag ment tant: lury o				ion Cemete	ry 9/7/2	012	Hill	Lsboro	ough, NC	
Baltimore,	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	_	22. Name and Address		rch F			- 04000	
_	⊕ □ = # 0	Ш	don't pt		1101 E. N				ore, N	1D 21202	_
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do no	/	g, such as cardiac or r	espiratory arr	est,		Approximate Interval Between	
~_P	h, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ial	resease					Onset and Death	
	Examiner		Due to (or as a cor	isequence of):						
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a cor	nsequence of):				_		_
4	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury								
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X	ittend or us	ian/		Fetal death	3 Ectopic pregnanc	у		2:	3d. Date of de Month	livery Day Year	
ion of Vital Records, P.O. Box 68760	requires that the areal restitutes be executed been signed by the attending physician and should be detached for use as the burial-transit	Be Completed by Physician/Medical	1	e of death	5 Other (specify)				WOHLIT	Day Tear	
0. ‡	led by detac	y P	Part II. Other significant conditions contributing to death but no	_	,	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?	
S,	n sign	g pa	Diubetes Hy	perlip	idemia		1 🗆 Y	res 2 🗆	No 3□P	robably 4 Unknow	n
orc	s bee	bet	Diubetes Hy severe gremin Ren	ul fai	lur -		24a. Was a		24b. Were au	topsy findings available	_
ည္	ite ha	E	Severe anemia Rena Hypertension				autop perfor 1 Yes	med)	death?	completion of cause of	
a	ertifica ctor, p	3e C	25. Was e referred to medical examiner?		26. Pla	ace of Death (Check or		Z/LI NO	I L Te	s 2 🗆 NO	1
on of Vital Records, P.O. Box 68760	his ce	유	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 🗆 ER/Out	patient 3 DOA Othe	r: 4 Nursing Home	5 Resid	ence 6	Other (Spec	rify)	
ָם נ	death. tror: After this certificate has by the funeral director, page 2 st	ficate:	27. Manner of Death 28a. Date of injury (Month, Day, Yea 2 Accident Investigation	28b. Tir inj	ury work?	?	d. Describe ho	ow injury o	occurred		
Sior	death cor: / the /		3 Suicide 6 Could not be	At home form	M 1 L	Yes 2 No					name of
Divisi	To the Funeral Director: A completed filled in by the funeral Director: A completed filled in by the funeral Director.	Cert	4 ☐ Homicide determined building, etc. (Sp		i, street, lactory, office	281	City or Town		Number or Ru	ral Route Number,	
L E	hours hours ineral	Medical	29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, de	eath occured at the time,	date and place, and c	ue to the cau	se(s) and	manner as sta	ated.	_
å H	in 24 he Fu	Mec	(Check 2 Medical Examiner: On the basis of examinonly one) 3 Certifying Nurse Practioner: To the best	nation and/or i of my knowle	investigation, in my opinion dge, death occurred at the	n, death occurred at the time, date and place, a	e time, date ar and due to the	nd place, a cause(s) a	and due to the	cause(s) and manner stat stated.	ed.
<u>-</u>	Vith Con		29b. Signature and title of certifier	1 11	29c. License	number	2	29d. Date	signed (Mont)	n, Day, Year)	
D.	2 ml		fill followed	Lw	132	6434			14/	roll	
	211.		30. Name and address of person who completed cause of death	(Item 23a) (Ty	pe, Print)	, / A	1	//		1/1/2 27	7
	Charl		Arthur Schroedcy (M) Home Phys. 31. Date fled (Month. Day Year) 32 Registry's S	icians	405 Dig	ital Dr	IVC CA	with	10Um	11/4/09/	ر
	Stat Registra		SEP 0 5 2012 Serve 32. Registar's S	parke							
DHMI	H 17 Rev 7/20	09									
				ORI	GINAL						

Physician/

Examiner

Funeral

Director

show

items 23a or 28a-f sho her must be notified at

Director

Funeral

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Medical

10a. State

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of N	/larylan	id / Depa	artmen <i>tificate</i>	t of H	lealth : Death	and M	1ental Hy	/giene Reg. No	20	12	28	138
	Physicia	an/	Decedent's Name (First, Michael Control of the	,								2. Date of D	eath		Vear	3. Time of	Death
	Medic Examir	cal	Donald D. No. 4a. Facility Name (if not institute)					4b City	Town or	Location of	of Dooth	Month 8	29	County o	012	10:00) P ^M
and the	Examil	lei	Hebrew Home				gton		:kvi]		Di Deatri		- 1	lontgo		У	
	Funeral		5. Social Security Number	6. Sex		ge (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth			ace (State o	r Foreign
	Director		578-26-3473 Usual Residence of Deceder		M 2 🗆 F	89	Yrs.					1-28-	,	1		ington	, DC
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	with the 23a oust be	Funeral Director	350 Market	Street	West,	#245		208						izen of Wh		•	
	death items ner m		11. Marital Status		2. Was Decedent Armed Forces		S. 13. \	Vas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race	- America	ın Indian,	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 ☐ № 3 🗶 Widowed 4 ☐ Divor		1X Yes 2 If Yes, Give Year or Dates.	No WW	II	☐ Yes				, , , , ,		Specify:	White, e	whi	te
5-0	hours "natur dical	Completed	15. Dece (Specify only hi	edent's Educ	ation		16a. Deced	lent's Usua			t of worki	20	16b. K	ind of Busi	iness/Ind	ustry	
121	thin 77	Com	Elementary/Secondary (0-1		College (1-4 or	5+)	life. De	O NOT use	retired)	uring mosi	O WOR	<i>ig</i>	_{E0}	doro.	1 Co.	/ernme	
ld 2	iled will Hygik	Be	17. Father's Name (First, Middle	e, Last)			necou		· 	18. Mothe	er's Name	(First, Middle			L GO	ver mile	1111
ylar	ld be f Menta arked atic e	입	Samuel Narc	lsenfe	1d					Ma:	ry Be	erlin					
Mar	2 shou th and 7 is m traum		19a. Informant's Name/Relation		,		1					Route Numb				,	
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mo	Page nent o ant: If ıry or		1 X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3 ☐ Re er <i>(Specify)</i>	emoval from Stat		emetery, cren g Davi						l .		•	, Virg	inia
Baltimore, Maryland 21215-0036	permit. Departr Imports any inju		21. Signature of Funeral Service	ce Licensee	Edward		1 22	. Name and	Addres	s of Facilit	у]	Danzans	ky-G	oldbe	erg		
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e open	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									Approximate Interval Betv Onset and D	veen				
	Medical Examiner		disease or condition resulting in death)	a.	Due to (or as										+		
	Examiner	ا <u>ا</u>	Sequentially list conditions, if any, leading to immediate	b.											_		
	ited d ansit	min	Cause Disease or injury	<	Due to (or as	a consequ	ence ot):										
	Attending Physician: The law requires that the death certificate be executed and each. Frideath. By the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	that initiated events resulting in death) Last	C.	Due to (or as	a consequ	ence of);										
09/	ate be	adice		d.													
Box 687	certific nding use as		IF FEMALE: 23b. Was decedent pregnant	230	c. If yes, outcom									23d. Date	of delive	v	
Box	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 Live Birth 4 Pregnant 9 Unknown	at time of d		Ectopic p Other (spe		/			- 1	Month		•	ear
P.O.	siclan: The law requires that the death certifical certificate has been signed by the attending principly page 2 should be detached for use as the		9 ∐ Unknown Part II. Other significant cond	litions contr			ulting in the u	nderlvina c	ause give	en in Part I		23e Did t	obacco u	sa contribi	ute to the	cause of de	ath?
Jenada Is, P.O.	uires th signe	d by												,		ably 4 🗆 L	
Records,	iw requals been 2 shou	Completed										24a. Was		24b. We	re autop	sy findings a	vailable
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Ser ital	Attending Physician: or death. ector: After this certific by the funeral director,	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No		spital:			-	Other	ce of Deat							
Nexcisenteld, on of Vital Recor	g Physer this neral d	e: To	27. Manner of Death		28a. Date of inj	ury	ER/Outpatien 28b. Time of		c. Injury	4 🛂 Nu at		ne 5 🗌 Resi 8d. Describe I			Specify)		
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certify	ing Physicia	an: To the best o	f my knowle	edge, death o	ccurred at	the time,	date and	place, an	d due to the c	ause(s) ar	id manner	as stated	1.	
	the Hi thin 24 the Fu		only one) 3 L Certify	ing Nurse P	On the basis of Practitioner: To t	examination ne best of m	and/or investi y knowledge,	death occu	rred at the	e time, date	curred at t e and plac	the time, date a e, and due to	the cause(s) and mar	ner as st	ated.	iner stated.
	o a wit		29b. Signature and title of certi	ner پر ہم کو	Mi	- Fo	izli, m		License	number 48	71		29d. Date	e signed (//			
			30. Name and address of person	on who com					200	0)-(a Fort	i M	-	12	212	
3			6121 Mont	rose	Rd	Re	ckvil		MC	>	20	a Fazl	1, PH				
	Stat Registra	C	31. Date filed (Month, Day, Year SEP 0	5 2012	32. Regist	rar's Signati	ure		,								
DHM	MH 17 Rev 06-2			4415	- Johnson	,	9							_			

Navcisenfeld, Donald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day William Joseph Neumann 2012ª Aug. 30 4:57A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Howard Columbia . Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 135-62-3049 53 1 1 M 2 | F June 29,1959 New York 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours efter death with the Maryland 10d. Inside City Limits Director rei", or items 23e or 28e-f s Examiner must be notified MD Carroll 1 Yes 2X No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1425 Searchlight Way 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 N Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the treumatic event, the 4 Project Leader Intl. Specialty Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Neumann Carol Siry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tre Craig Neumann / son 1425 Searchlight Way Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of importent: if it is eny injury or conce. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/31/12 Woodbine, MD . Signature of Ineral Service Licensee 32 Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD21029 23a. Part 1. Enter the disea Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ HEPATOCELLULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day ☐ Yes 2 ☐ No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KIDNEY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Ves 2 A No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) NO MD D72139 Huguel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C 6336 Q. ABBAS MD COLUMBIA CEDAR LANE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month.-Day: Year) -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James 8 24 1648 PM Norwood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Center Southern Mayband Clinta rinec If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Dav. Year Months **Director** 39 578-04-0732 1 **X** M 2 □ F Jan. 11, 1973 Washington, DC Yrs Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2 No Prince Georges Upper Marlboro MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a United States 20774 182 Greenmeadow Way #G items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Information 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Technology Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Ann Wood James William Norwood, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2510 Virginia Ave., N.W.#709N, Washington, DC 20037 (mother) Mary Ann Norwood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory SeptDate 07, 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State 2012 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Funeral Service Licensee 933 Gist Ave. Silver Spring, MD 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Minutes Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transi VERYS Due to (or as a consequence of) Physician/Medical use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the at a be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tobacco 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Director: þ within 24 hours after

To the Funeral Directory

completely filled in by

9a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occur of the basis of examination and/or investigational one) 2. Medical Examiner: On the basis of examination and/or investigational one of the basis of my knowledge, death occur of the basis of examination and/or investigation.	ion, in my opinion, death occurred at the time, dat	e and place, and due to the cause(s) and manner stated.
b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Be Mo	D0071982	8/24/12
de de la companya de		

Rd Sutte #210

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

6 Could not be

determined

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16:20 PM arun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Bultinone 04 +, more 1541 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min. 19-96-0343 Director 1 ☑ M 2 □ F Usual Residence of Decedent Cylan permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hyglene. Importent: If Item 27 is merked other then "neturel", or Iteme 23e or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8404 Son Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Taran Brue Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Ś Maryland 21215-0036 1 Yes 2 No If Yes, Give Completed 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry econdary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 19a. Informant's Name/Relationship (Type, Print) reza Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donasion 22-Name and Address 21. Signat P. A. 21216 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Hemorrhore set and Death Ameriovenail Pnysician Waltermution disease or condition Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). sicien end buriel-trensit Exami Hospitel or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ettending physicien for use es the burle Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day ed by the e 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ete hes been signed pege 2 should be de à 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform After this certificete 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ျှ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours efter deeth.

To the Funeral Director: After this of completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature 18260 on who completed cause of death (Item 23a) (Type, Print) 1/201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

SEP 0 5 2012

12-06377		Please Type or	Print in Blac	k Indeli	ible ink. Ens	sure All Copi	es Are Lo	egible.				
William Lee Napier,	Jr	State of	f Maryland / D	epartm	ent of Health	and Mental H	lygiene		001	_	001	1
	1- For State Registrar			Certifica	ate of Death			Reg. No.	201	2	281	4
Physician/	1. Decedent's	s Name (First, Middle,Last)					2. Date of De Month		Year		of Death	
Medical Examiner			WILLIAM	LEE	NAPIER,	JR.	Month August 2	4, 2012	ı val	065	0 hrs	

·	1- For State Certificate of Death Reg. No. 20 2 28 4
Physician/ ledical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
1	4a. Facility Name (if not institution, give street and number) Rear of Rock Creek Park 4b. City, Town, or Location of Death Anne Arundel
Funeral Director	5. Social Security Number 217 13 4174 1 M 2 F 26 Yrs. 7. Age (In yrs. last birthday) 4 1 M 2 F 26 Yrs. 7. Age (In yrs. last birthday) 4 1 M 2 F 26 Yrs. 7. Age (In yrs. last birthday) 4 1 M 2 F 26 Yrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
i ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Pasadena 1 Yes 2 X No
th the Maryland 23a nr 28a-f show notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A.
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked rather than "natural", ar items 23a ar 28a-f she or of the traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Sive Year 1 Yes, Give Year
5 72 hours after "natural" ral Examine	15 December 15 Struction (Specificable Market and completed) 15a December 15upl Occupation (Size kind of work done 15b Kind of Business/Industry
ID 21215-0036 should be filed within 72 hours and Mental Hygiene. T is marked ruther than "naturnatic event, the Medical Exam To Be Completed It	Building Restoration Construction 17. Father's Name (First, Middle, Last) William Lee Napier, Sr. Denise Lynn McKay
, MD 2121 and 2 should be fi fealth and Mental 1 from 27 is marked fram 27 is marked frammatic event, To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Estell - Mother 4420 Purple Martins Rd Pasadena, MD 21122
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 8/27/12 Baltimore, MD
	21. Signature Funeral Sarvice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Heroin) Intoxication Death Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ecuted and transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
'60, ate be ex physician he burial -	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify) g Unknown
S, P.O. uires that the n signed by 1 ld be detache ed by Pl	1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, I at or Attending Physician: The law requires as after death. 1 Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
f Vital Rec Physician: The I or this certificate ral director, page	25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: Scene
Division of spital or Attending Phours after death. neral Director: After filled in by the funeral Certification: T	1 Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be 1 Suicide 6 Could not be 2 Suicide 6 Could not be 3 Suicide 8 S
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificatif	Zeal. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
0 State	Loo Alberta Circut

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per FH G931 9/05/2012 JH
State of Maryland / Department of Health and Mental Hygiene

			For State Of IVIS	•	epartment of Heal Ce <i>rtificate of Deat</i>				0 00111
	Discolate		Decedent's Name (First, Middle, Last)		50.1	2. Date	Reg.	201	3. Time of Death
	Physicia Medic		ELLEY ROY NELSO	N		- 1	ust 2	9,2012	1106 am
	Examin	er	4a. Facility Name (if not institution, give street and number)	-ortal	4b City, Town, or Locat	tion of Death		4c. County of Dea	th
	Funeral		5. Social Section Number 6. Sex 7. Age 1 X M 2 F	(In yrs. last birtho		nder 24 Hrs. 8. Date	of Birth		rthplace (State or Foreign
	Director		248-20-7604 14AM 2 ☐ F Usual Residence of Decedent	90 Yr	rs. Months Days Hou	urs Min. (Mor APR	of Birth oth, Day, Yea 24	sot	CAROLINA
	and show lat	or	10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	Maryla 28a-f	irect	MARYLAND HARFORD CO		ABERDE	EN			1 ☐ Yes 2 🛣 No
	th the	al D	10e. Street and Number		10f. Zip Code			Citizen of What C	ountry?
	ath wi	Funeral Director	1222 PERRYMAN RD. APT 31 11. Marital Status 12. Was Decedent E		21001	Origin? (Specify Yes)		U.S.A.	orican Indian
326	e filed within 72 hours after death with the Maryland ttal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 M Widowed 4 Divorced Armed Forces? 1 A Yes 2 1 If Yes, Give Year or Dates. A	No	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex1 Yes 2 XNo Specify		c.)	Black, White	te, etc.
<u>ဂ</u>	hour: "natur dical l	plete	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occupation Give kind of work done during	most of working	16b	o. Kind of Business	
9500-61212	thin 72 sne. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5-	+) lii	fe. DO NOT use retired)			DDTMARE	
	filed wi tal Hygie d other event, tl	Be (12th 17. Father's Name (First, Middle, Last)	CAR	RPENTRY/HOME I	MPKOVEMENT Mother's Name (First, N	liddle, Maid	PRIVATE len Surname)	
Jan	d be fi Vental arked atic ev	우	ELLEY LAWSON NELSON			MAMMIE NEL			
Maryland	1 and 2 should be file of Health and Mental fitem 27 is marked of rother traumatic eve	10	19a. Informant's Name/Relationship (Type, Print) daugh		Mailing Address (Street and Nu				
	1 and 2 of Health item 2 other t		Cathryn A. Nelson Hoffler/ 20a. Method of Disposition		25 Walton Cro	ssing Apt.		, Atlanta	
ē	9 <u> 5</u>		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	crematory or other place) SON FOREST	09-11-12			LLS, MARYLAND
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of average incomes	Omittee	22. Name and Address of F WILLIAM C BRO 1206 W NORTH		_		
	_		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not			-	- (Approximate
-	Ph _y sician/	A 03	Immediate Cause (Final disease or condition						Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a	consequence of)	: K				
	7 t	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	xan	Cause (Disease or iinjury that initiated events	consequence of)	arhere.				
0	be ex sician burial	cal	d	,					
2/60	ificate ng phy as the		IF FEMALE:						
X X	th certifi ttending or use a	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of the past 12 months?	2 🗌 Fetal death	3 Ectopic pregnancy			23d. Date of de	
. Box	the atte	ysic	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death	5 Other (specify)			Month	Day Year
J.	that the ned by the detach		Part II, Other significant conditions contributing to death but	_		Part I. 23e	. Did tobacc	co use contribute t	o the cause of death?
dS,	requires been sign should be	Completed by	sypentension, Cereb	rovasci	uar Acciden	nt	1 🗌 Yes	2 ☑ No 3 ☐ F	Probably 4 🗆 Unknown
S	law re nas be e 2 sho	nple				24a	. Was an autopsy	prior to	utopsy findings available completion of cause of
2	n: The law r ficate has b r, page 2 s		25. Was case referred to medical			1 [performed Yes 2		s 2 No
VIT a	s certii	To Be	examiner? Hospital:	ent 2 T FR/Outr	_ Other:	Death (Check only one Nursing Home 5		6 ☐ Othor /Spo	oifu)
0	ng Phy ter thi neral o		27. Manner of Death 1 Matural 5 Pending (Month, Day,	y 28b. Tin	ne of 28c. Injury at			ijury occurred	City)
<u>0</u>	tendii death. tor: Ai the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes			•	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,		building, etc	. (Specify)	n, street, factory, office	City	or Town, St		
	he Hosp in 24 hou he Fune pleted fi	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of results of the control of the basis of examiner: On the basis of examiner: To the basis of exami	amination and/or i	investigation, in my opinion, dea	ath occurred at the time,	date and pla	ace, and due to the	cause(s) and manner stated.
	Vith Vith Com		29b. Signature and title of certifier	10	29c. License numb) 7	29d.	Date signed (Mont	th, Day, Year)
	X/ In		30. Name and address of person who completed cause of	th (Item 23a) (Tu	De Print)	-/	1 8	174/10	0
	b,		Hafiz Ahmad Kaza, r	n.D.9	o 18 prypro	(Genera	el L	tospital	
\$1.	Stat	te	31. Date filed (Month, Day, Year) 82. Registra	r's Signature	arke			0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Susan H. O'Malley September 2012 0800 a^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Aug 24, Year 945 Pennsylvania 67 Director 219-48-1377 1 🗆 M 2 🗓 F 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-f show 10a. State 10b. County "netural", or items 23a or 28e-f sho Director 1 Yes 2 No Kensington MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20895 9901 LaDuke Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "netur Injury or other traumetic event, <u>the Medical I</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Editor/Writer Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary H. Wickham Charles B. Heinemann, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
III/brother 936 Nichols Drive Laurel, MD 20707 19a. Informant's Name/Relationship (Type, Print) Charles B. Heinemann, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State inal Journey Crematory 09/04/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 MD 21029 Heckrotte, P.A. Clarksville, Beverly L. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Acute Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Right basal ganglia stroke extended to sub arachnoid or Attending Physician: The law requires that the death certificete be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erel Director: After this certificate has filled in by the funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work?
1 Yes 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or At 24 hours after determined To the Hospital within 24 hours a To the Funerel L Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 Melecel

151

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Nooshin Farr, M.D. 1500 Forest Glen Rd Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Edward Oltman 3:22 9M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medstar Harbor Hospital Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 🗆 Hours 11 O 2 83 220 20 2329 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 8504 Jenkins Rd 21122 U.S.A. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 🗷 Yes 2 🗆 No 1951 -Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1957 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Port of Baltimore Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Oltman Helen Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 7789 Notley Rd Pasadena, MD Christopher Oltman - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem 9/4/2012 Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Fund al Se deicensee 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Sepsis disease or condition Medical resulting in death) **Examiner** Visceral Adenocarcima Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Dun to Lor as a nonnecumnor of -transit and resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated RES UD 1 MD August 31, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) Sagar, Shanover St. Baltimore MD 3001 Ala Eddin

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible

	1 - For State Registrar	State of Maryland / Dep	partment of Health a ertificate of Death	and Mental Hyg	•				
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last) 4a. Facility Name (if not institution, give street)	·	4b. City, Town, or Location of	2. Date of Dear Month August	31 2012 6:50 P M 4c. County of Death				
Funeral Director	Greater Baltimor 5. Social Security Number 092-28-5666 Usual Residence of Decedent	e Medical Center 7. Age (In yrs. last birthday) 1 2 15 F 82 Yrs.		8. Date of Birth (Month, Day, 11/30/	Year) Country)				
15-0036 72 hours after death with the Maryland n "matural", or items 23a or 28a-f show fedical Examiner must be notified at npleted by Funeral Director	NC 10e. Street and Number	10c. City, Town or L	Tabor C		10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?				
death with t items 23a ner must be Funeral		Armed Forces?	28463 Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	USA 14. Race - American Indian, Black, White, etc.				
21215-0036 ifthin 72 hours after death inchen. "return "natural", or item the Medical Examiner in Completed by Fui	1 Never Married 2 Married 3 X Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of	1 ☐ Yes 2 M No If Yes, Give Year or Dates. tion 16a. Dec:	1 ☐ Yes 2 ♣ No Specify:		Specify: Black 16b. Kind of Business/Industry				
d 2121 led within 72 Hygiene other than " ent, the Me		College (1-4 or 5+)	e kind of work done during most of DO NOT use retired) Laborer 18. Mother	's Name (First, Middle, N	Clothing Factory				
Maryland 21215-0036 2 should be filed within 72 hours after this and Mental Hygiener 77 is marked other than "natural", o traumatic event, the Medical Exami To Be Completed by	Ma 19a. Informant's Name/Relationship (Type, Sanders Chestnut / Son		ling Address (Street and Number Radnor Avenue, Baltin	Gus or Rural Route Number,	sie Lewis City or Town, State, Zip Code)				
Ore, or other	20a. Method of Disposition 1 □ Buria! 2 □ Cremation 3 Rer 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp		Date 9/8/2012	20c. Location - City or Town, State Tabor City, NC				
Baltim permit. Pag Departmen Important: any injury once.	21. Signature Funeral Service Licensee		22. Name and Address of Facility aughn C. Greene Funera		ork Road, Baltimore, MD 21212				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)		ry pertension		Approximate Interval Between Onset and Death				
ate be executed hysician and the burial-transit circal Examiner		Due to (or as a consequence of): Due to (or as a consequence of):		7					
s, P.O. Box 6876C res that the death certificate I signed by the attending phys d be detached for use as the by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnancy 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year				
Division of Vital Records, P.O. Box 6876 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The fact he Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Med	Part 11. Other significant conditions contrib Uninary tad GI bleeding	outing to death but not resulting in the	underlying cause given in Part I.	1 Your 24a. Was all autops	sy prior to completion of cause of				
Vital Rehysician: The his certificate Il director, pag	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	oital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	(Check only one)	death? 2 No 1 Yes 2 No ence 6 Other (Specify)				
Division of Vital Records, no the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should be Medical Certificate: To Be Completed I	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury	of 28c. Injury at work? M 1 □ Yes 2 □ t	28d. Describe ho	w injury occurred				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certific	29a. Certifier 1 Certifying Physicia	28e. Place of Injury - At home, farm, si building, etc. (Specify) n: To the best of my knowledge, death	occurred at the time, date and p	City or Town	ise(s) and manner as stated.				
To the Ho within 24 To the Fu complete		On the basis of examination and/or inversactitioner: To the best of my knowledge		and place, and due to the	9d. Date signed (Month, Day, Year)				
5	30. Name and address of person who comp	cleted cause of death (Item 23a) (Type, Chatham 6			, Baltimore, Md 21204				
State Registrar	31. Date filed (Month, Day, Year) SEP 0 5 2012	32 Tegistrar's Signature	ale		12120y				

State Registrar DHMH 17 Rev 06-2011

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AMEND ITEM#30perDVR, G931, 975/2012, WS
State of Maryland 7 Department of Health and Mental Hygiene 20 | 2 8 | 4 7 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Day 7 Stanley 2012 Charles Paschall 06:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 29449 Charlotte Hall Road Charlotte Hall St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | Dec. | 21 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Director 61 Yrs 1950 Japan 22056-9799 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charlotte Hall St. Mary's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 \square Never Married 2 \square Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 l and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Inspector Fiber Optics 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Russell Paschall Eileen Μ. Pollard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Michael Derrickson 2705 Cecil Drive, Chester MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of Sep^{pate} 2012 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Maryland Veterans Cen Crownsville, MAryland 21. Signature of Funeral Service Lowes 22. Name and Address of Facility ame and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 any. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KENAL PAILURE 5 4 EARS disease or condition Medical resulting in death) to (or as a consequence of) Examiner 4 PURTONSION USARF Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury mellitus Type I sician and burial-trans t that initiated events Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ō Month Day Year 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: ompleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and little of c H37228mD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22333 Greenview Pkwy. Stephen Cafferty Great Mills, Md 20634 0 5 2012 32. Registrar's Signature State Registrar

	Please	Type or Print in B						Legible.	
	for State Registrar	State of Maryland		rtment of F tificate of D		/lental Hy	giene Reg. No.	2012	28148
Physician/ Medical	Decedent's Name (First, Middle, Las CECELIA B. PATRICK	t)				2. Date of De Month AUGUST 3	eath Day	/ Year	3. Time of Death
Examiner	4a. Facility Name (if not institution, give 518 CHESTER RIVER BE 5. Social Security Number 6. Se	EACH RD.	t hirthday)	4b. City, Town, or GRASONVIL	Location of Death LE If Under 24 Hrs.	8. Date of Bir	4c.	County of Deat UEEN ANNE	h
Funeral Director		□ M 2 XX F 95	Yrs. Town or Loc	Months Days	Hours Min.	(Month, Da	ay, Year)		mD 10d. Inside City Limits
he Maryland or 28a-f sho notified at Director	MD QUEEN ANN 10e. Street and Number		ASONVII	.LE					1 Yes XX No
vith th	518 CHESTER RIVER	DEACH DO		10f. Zip Code 21638			10g. Cit	izen of What Co USA	untry?
leath with thems 23a er must be	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	/as Decedent of His	spanic Origin? (Sp	ecify Yes or No-	.	14. Race - Ame	
tter of amin	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.		Yes, specify Cubar		Hican, etc.)		Black, White Specify: WHI	,
2 hour "natu	15. Decedent's Ed (Specify only highest gra		(Give k	ent's Usual Occupa ind of work done d	ition uring most of work	ing	16b. Ki	nd of Business/	Industry
within 72 hours a giene. In than "natural" the Medical Ex. Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) INESS OWNE	R		LIG	QUOR STOR	E
oe filed vental Hyg ked othe cevent,	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	, Maiden S	Surname)	
uld be Ment marke natic	ALEXANDER BROWN				CECELIA				
2 sho Ith and 27 is r traur	19a. Informant's Name/Relationship (Ty FRANCIS THOMAS PATRI	· · · · /	,	g Address (Street a IESTER RIVE					Code)
f Heal item other	20a, Method of Disposition	20b. Pla	ce of Dispos	sition (Name of		Date		cation - City or	Town, State
Page ment c ant: If ury or	1XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State HOLY		atory or other place CEMETERY	9.4.2	2012	BROOL	KLYN, MD.	
permit. Departi Import any inj once.	21. Signature of Funeral Service Lisens	ee Q	22 F1	Name and Addres	SOLE P.A.				
452 6 6	23a Part 1 Enter the Use the Lift communication	M01148		the mode of dvino				51	Approximate
Physician/ Medical Examiner	23a. Part 1. Enter he dise se, ir comp shoc, or heart failure. So only or immediate use (Final disease or condition resulting in death)	a. Due to (or as a consequer	ha						Interval Between
cate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer Due to (or as a consequer							
tth certifi ittending for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 Live Birth 2 Fetal of the second of	death 3	Ectopic pregnancy Other (specify)	/		:	23d. Date of del Month	ivery Day Year
requires that the dea been signed by the a should be detached?	Part II. Other significant conditions co	ontributing to death but not result	ting in the ur	derlying cause giv	en in Part I.				the cause of death?
sician: The law require certificate has been si lirector, page 2 should Be Completed								prior to death?	copsy findings available completion of cause of 2 No
certific rector	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ce of Death (Chec		1364		
ding Physi h. After this c funeral dir	27. Manner of Death 1 Natural 5 Pending	(Month, Day, Year)	R/Outpatient 8b. Time of injury	28c. Injury	4 □ Nursing Ho	ome 5 Resi 28d. Describe			fy)
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		e, farm, stre		tes 2 🗆 NO	28f. Location (City or Tox		l Number or Rui	al Route Number,
he Hospita in 24 hours he Funeral pletely filled	(Check 2 L Medical Exami	L sician: To the best of my knowled ner: On the basis of examination a se Practition∳r: To the best of my	and/or investi	gation, in my opinio	n, death occurred a	t the time, date a	and place,	and due to the	ause(s) and manner stated.
Vith Vith To t	29b. Signature and title of certifier	Sty		29c. License	a o 9 4			PTEMBER 4	
POY	30. Name and address of person who c	ompleted cause of death (Item 2:		int)		21061			
State Registrar	31. Date filed (Month, Day, Year) SEP 0 5 2012	32. Registrar's Signatur	Parke	,					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Sept. 01, Alla Pietsch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts of Silver Spring Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month Day, 1 □ M 2 🛛 F Months Days Hours Min 1918 Director 214-52-2967 94 June Usual Residence of Decedent 28a-f show 10b. County 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code Funeral 14400 Homecrest Rd. #134 20906 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 ☐ Widowed 4 🏋 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Linguist Scientist ie 1 and 2 should be filed wit t of Health and Mental Hygie If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Pantelemon Popoff Helen Sokoloff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra C. Fletcher (daughtet) 15012 Whitegate Rd. Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otl SeptDate 05. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funaral Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ned by the a 9 Unknown P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by sign. Hypertension Records, 24a. Was an autopsy performe of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDQA 4 Nursing Home 5 Residence 6 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending Natural Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) b determined .= within 24 hours a To the Funeral D completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe D43237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V

1 Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian. Specify: White 16b. Kind of Business Industry Government Consulting 20c. Location - City or Town, State Beltsville, MD. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Tes Assist. Liv 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 09/01/2012 14201 Laurel Park Dr. #102, Laurel, MD 20707

3. Time of Death

9. Birthplace (State or Foreign

Montgomery

1:45 p. M

Russia

10d. Inside City Limits

State Registra

Paul Armstrong, M.D.

SEP 0 5 2012

31. Date filed (Month, Day, Year)

12-06510 Jane Frances Quin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 28150

		I- For State	Certificat	e of Death	R	eg. No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Dea Month	Day Year	3. Time of Death 0915 hrs
ledical Examin	_	Jane Frances Quin		I	August 29	9, 2012 4c. County of Death	0915 1118
		4a. Facility Name (if not institution, give street and numbe Anne Arundel Hospital	r)	4b. City, Town, or Loca Annapolis	ition of Death	Anne Arundel	
	=	· · · · · · · · · · · · · · · · · · ·	ge (In yrs. last birthd		Under 24Hrs. 8. Date of Bi	rth (MM/DD/YYYY) 9. Birth	place (State or
Funeral Director		142-46-1622 1 M 2 XF	58		lours Min.	Foreign	New Jersey
<u> </u>		Usual Residence of Decedent 10a. State 10b. County	10c, City, Town or	Location			10d. Inside City Limits
Maryland 28a-f show any 1 at once.		MD Anne Arundel	Annapol				1 X Yes 2 No
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and N - rital Hygiene. Iftem 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number		10f. Zip Code		109. Citizen of What Count	ry?
with th		2574 Riva Road, Unit 7A 11. Marital Status 12. Was Decede		21401 3. Was Decedent of Hispani	c Origin? (Specify Yes or No	U.S.A. 14. Race - Americ	an Indian, Black,
death r item	Funeral	1 Never Married 2 Married Armed Force	2 X No	If Yes, specify Cuban, Me		White, etc.	
after al", o	ğ.	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 No sp		Specify: Whi	
hours natur Exam		15. Decedent's Education (Specify only highest grade or	du	cedent's Usual Dccupation (ring most of working life. DO	NOT use retired)	16b. Kind of Business/in	dustry
36 in 72 han "	Completed	Elementary/Secondary (0-12) College (1-4 c		iniatrativo	Dorgonnol	Mental Hea	al+h
21215-0036 uld be filed within 7 N ratal Hygiene. marked other than c revent, the Medica	탉	12 17. Father's Name (First, Middle, Last)	Adı	ninistrative 18.M	Nother's Name (First, Middle,	Maiden Surname)	3.1.0(1)
215 e fileo tal Hy ked o	Be	James Francis Quin_			eraldine	Losco	
213 ould b d l N :n s mar	ᆰ	19a. Informant's Name/Relationsnip (Type, Print)	- 1		d Number or Rural Route Nu		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hour Department of Health and N. sntal Hygiene. Important: If item 27 is marked other than "nati injury or other traumatic event, the Medical Exa	L	Susan Randt / Sister	13	3401 Belle Ch Disposition (Name of cemete	asse Blvd., U	Init 315, Lat	<u>ove</u> State
s lan sf Hea		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from		or other place)	ry, cate	20c. Location - Oity of	own, diate
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 X Donation 5 Other Specify:	Anatomy	Gifts Registry	09/05/2012	Hanover, N	Maryland
Salti ermit. epartr nportijury		21. Signature of Fune al Service License			acility Anatomy	-	-
	4	23a. Part I. Enter the disease, or complications that causi	ed the death. Do not e	7522 Connell enter the mode of dying, suc	ey Dr., Ste.	P, Hanover, rest, shock, or heart	Approximate Interval
Physician //Medical		failure. List only one cause on each line.					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Chpking Due to (or as a core	nsequence of):				
		Sequentially list conditions, b.					
•	iner	if any, leading to immediate Due to (or as a col	sequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a column of the	sequence of):				
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760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				Log L D L of d live	
3760, ficate b		23b. Was decedent pregnant in the 1 Live birth	ome of pregnancy 2	Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending p	cial	past 12 months?	at time of death 5	Other (Specify)			
O. Boy that the death ned by the att detached for	Physician	1 Yes 2 No 9 Unknown 9 Unknown	n t 1 - 1 - 1 - 1 - 1	All a consideration and an arrangement	in Port I 23e Did	tobacco use contribute to	he cause of death?
, P.O.	by P	Part II. Other significant conditions contributing to de	ath but not resulting i	n the underlying cause giver		es 2 No 3 Prob	
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COFC	Completed					ormed? death?	ompletion of cause of
tal Reco	S			26 Place of	1 Yes	2 ✓ No 1 Ye	s 2 No
Ing Physician: After this certifi	Be	25. Was case referred to medical examiner? Hospital: 1 Ves 2 No	itient 2 ER/Out		er4 Nursing Home 5	Residence 6 Other	
of Vi	년:	27 Manner of Death 28a, Date of	niury 28b. Ti	me of Injury 28c. Injury a		how injury occurred	
ion (tending eath.	tion	1 Natural 5 Pending Aug 25, 20	1'2 0130	hrs 1 Yes	2 ✓ No Subject ch	pked on food bolus	
O A D D So	Certification:	3 Suicide Could not be		m, street, factory, office build		(Street and Number or Ru State) oad, Annapolis, MD	ral Route Number, City
Divi		29a. Certifier Continue Physician: To the hest of	ingle Family Ho				ed.
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of earnyming Physician. To the basis of earnyming Physician.	xamination and/or inv	estigation, in my opinion, de	eath occurred at the time, dat	e and place, and due to the	e cause(s)
To To COIT	Me	29b. Signature and title of certifier	4	29c. License no	umber	29d. Date signed (Mon	nth, Day, Year)
		(allell)	1	O.C.M.I	= .	August 30, 2012	
		30. Name and address of person who completed cause			D-16 MD-04000		
		Zabiullah Ali, M.D. Assistant Medical		W. Baltimore Street,	Baltimore, MD 21223		
St Regis	tate trar		trar's Signature	a dad			
DHMH 17 Rev 1/2		VLT V V LVIL / CBANCA	ORI	GINAL			
			-14			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2012 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia 2012 Estella Rielly September 5:05pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Owings Mills Baltimore 4 Flemingham Court If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Director 212-24-7563 1 □ M 2**X** F 85 Yrs. Aug 2, 1927 Maryland Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🔀 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 4 Flemingham Court U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher 12 St Matthews School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Krach George Adelaide Pitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 Daughter Reisterstown, MD Sharon Horstman 236 Highfalcon Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Other (Specify) 4 Donation 5 Carroll Cremation Inc Hampstead, MD 21. Sig fatur rvice Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 J. Wayne Osterling e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hist only one cause on each line. wock, or heart fail Immediate Ca. Final disease or condition resulting in death) Onset and Death Physician/ enos le Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 687605 The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months 1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death Leen signed by the sanould be detached g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an performed? Yes 2 N 1 Yes 2 No

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

21136

25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death 1 Natural
2 Accident
3 Suicide 5 Pending

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

Other: 28c. Injury at work? 1 Yes 2 No

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

4 Homicide

29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 7122

cress of person who completed cause of death (Item 23a) (Type, Print) ~ · wkode

Investigation 6 Could not be

determined

State

Completed

Be

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Certificate:

Medical

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s after death, Il Director: After this c ed in by the funeral dire

To the Hospital
within 24 hours a
To the Funeral C
completely filled

filled in by

Division of Vital Hospital or Attending Physician:

> 31. Date filed (Mon Registrar

7			Please	Type or Prin									_	ble.	
			For	State of Ma	ıryland					and N	lental Hy	gien	e	1.0	00150
			State Registrar			Cer	tificate	e of D	Death			Reg. N	<u> 2 U</u>	12	28152
	Physicia Medic		1. Decedent's Name (First, Middle, La Harry Reeder,	Jr.							2. Date of De Month		3 2	Year 2	3. Time of Death 2142 M
	Examin	er	4a. Facility Name (if not institution, giv	e street and number)	al		45. Ohy	Town, pr	Location	of Death	0	4	c. County o	of Death	
	Funeral		012 00 2120		(In yrs. la	st birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da			9. Birth	place (State or Foreign try)
	Director		Usual Residence of Decedent	1 🛣 M 2 🗆 F	48	Yrs.					04/05	/196	54	Mai	cyland
	yland f sho	tor	10a. State 10b. County		10c. City, Town or Location								1	0d. Inside City Limits	
	e Mar r 28a- notifi	Director	MD 10e. Street and Number		Ва	alt imon		0 - 1-							1 ☑ Yes 2 ☐ No
	with th		2221 Eutaw Plac	$a = \lambda n + 3$			10f. Zip	217				_	itizen of W J.S.A.		ntry?
	eath v	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S		Vas Deced	ent of His			cify Yes or No		14. Race	•	an Indian,
36	after d ", or i camin	۵	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give	No	1	Yes, spec			Cut	Rican, etc.)			, White,	
ဝို	atura cal Ex	etec	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.		16a. Deced				Domi	inican	1Ch	Specify: Kind of Bus		
215	in 72 h e. nan "n	Completed	(Specify only highest g Elementary/Secondary (0-12)		r)	(Give I	aind of wor NOT use	k done d	luring mos	t of worki	ing	160.	KING OF BUS	siness/in	oustry
2	d with lygien ther th	a	ÜNK			<u>Nev</u>	ver W	orke					Never	Wo	cked
anc	be file antal F ked or c evel	To B	17. Father's Name (First, Middle, Last) Harry Reeder,	Sr.					18. Moth		e (First, Middle		n Surname)		
ary	ind Me s mar		19a. Informant's Name/Relationship (19b. Mailin	g Address	(Street a			Barro Il Route Numb		or Town. Sta	ate. Zip (Code)
Σ	nd 2 sl ealth a n 27 i		Thomas Reeder /	Brother			_				3, Ba	-			
ore	ge 1 and it of H. itel		20a. Method of Disposition 1 Durial 2 Cremation 3	☐ Removal from State	CE	lace of Dispo emetery, cren	natory or o	ther place			Date		Location - (•	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☑ Donation 5 ☐ Other (Spec 21. Signatur of Funeral Service Licer		Anat	tany Gif	ts Rec		<u> </u>		5/2012 Anatomy				
Ba	Depar Depar Impor any ir		> Kar	R.										_	4D 21076
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on the contract of the contr	the death	. Do not ente	r the mod	of dying	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition resulting in death)	a Key	ual	my (tau	we	}						Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as	consequ	ence //i:	Prece	44.0	ain						Unk
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	ence of):	14 CEB	unc	YUL						Op. 12
	e executed cian and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c		V									
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Box 68760	eath certificate bu attending physic I for use as the b	ledic		d											
89 x	ending r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnar	ncy Ideath 3.] Ectopic r	oregnanc	ev.			-	23d. Date	of deliv	ery
Bo	e death the att hed fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at g ☐ Unknown			Other (sp		,				Mon	th	Day Year
P.d.	Attending Physician: The law requires that the death certificate b stroath. stroath.	Completed by Physician/Medic	Part II. Other significant conditions	contributing to death bu	ıt not resu	ulting in the u	nderlying o	cause giv	ren in Part	I.	23e. Did	tobacco	use contril	oute to th	ne cause of death?
ds, l	v requires to been signal be	ed b									1 🗆	Yes :	2 □ No :	3 🗆 Pro	bably 4 Unknown
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ital	sician certifi irector	Be	25. Was case referred to medical exampler? 1	Hospital:		/		Otho	ace of Dea						
<u>></u>	g Physer this	e: 10	27. Manner of Death	28a. Date of injur	у	ER/Outpatier 28b. Time of		Bc. Injury	4⊔Nu ∕at	ursing Ho	ome 5 Res 28d. Describe)
o	eath. or: Aft the fur	fical	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not		rear)	injury —	М	work	? Yes 2 🗆	No					
Division of Vital Records,	of or Attenders after deat Director:	Certificate:	4 Homicide determined				eet, factory	, office			28f. Location City or To			or Rura	Route Number,
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Medical	Check 2 ☐ Medical Exar	ysician: To the best of a niner: On the basis of ex	amination	and/or invest	igation, in a	my opinio	on, death or	ccurred a	t the time, date	and place	ce, and due	to the ca	use(s) and manner stated
	To the within 2 To the comple	Σ	29b. Signature and title of defifier	rse Practitioner: To the	best of m	y knowledge			he time, da number	tu and pla	and duriti		ate signed		
			I Mille	W				00	9669	539	} -	_	Tripo		
			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, F	Print) S	. (///	too	ari	. B/L 1:		7		
	Sta	te	31. Date filed (Mo/th,(31, Year)	32. Registra	r's Signat	ure /	<i>y y y</i>		. • • •		- 0,,,,,				101
	Registr		SEP 0 5 2012	Buch	A.	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ August 31, 2012 1:20 P Kenneth Leo Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 13715 Castle Cliff Way Silver Spring 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sept 13, Months Hours 1942 Rhode Island 035-28-9670 Usual Residence of Decede Director 1 ▼ M 2 □ F 69 Yrs 28a-f show 10b. County ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 13715 Castle Cliff Way items ? within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian er than "natural", or iter the Medical Examiner rmed Forces'
Yes 2 Black, White, etc. þ 1 Never Married 2 X Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1960-64 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Dept. of Defense Aviation Analyst event, Page 1 and 2 should be filed went of Health and Mental Hyg ant: If item 27 is marked oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ones. Virginia Burdick Leo Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13715 Castle Cliff Way Silver Spring, MD 20904 Merry F. Robert/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/05/12 Woodsine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Corticobasal Degeneration Medical resulting in death) Due to (or as a consequence of) Examiner Parkinsonism Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury Exami use as the bunaf-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the alid be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has Hospital or Attending Physician; The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending work?
1 Yes 2 No Investigation __ Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [To the I within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) September 4, 2012 D37142

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850 31. Date filed (Month, Day, Year)

SEP 0 5 2012

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 Ced

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Physicia	n/	State Registrar 1. Decedent's Nam	ne (First, Middle	, Last) Geor	gene	Mary	<i>ertificate</i> Re	of D g1as			2. Date of De Month	ath	No. 2 (Year	3. Time of 12:51	
Medic Examin	- 11			give street and num		rialy	4b. City, T		Location of	Death	Aug.	3.	4c. County Balt	of Death	e Co.	
Funeral Director		5. Social Security N 213-70- Usual Residence	lumber 1576	6. Sex 1 \(\triangle M \) 2 \(\overline{\mathbb{K}} \) F	7. Age (In	yrs. last birthda Yrs	y) If Under Months		If Under 24 Hours	Min.	8. Date of Bir (Month, Da	ıy, Yea	r)	9. Birthp Coun	olace (State o	r Foreign
faryland 8a-f show tified at	ector	10a. State	10b. County	altimore	10	c. City, Town or	Location		Edo	eme	re			1	0d. Inside Ci	ity Limits
with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Nu		oint Lane		-	10f. Zip	Code 1219					Citizen of V		-	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status 1 Never Marital Status		If Yes Giv	rces? 2 X No e	in U.S.	3. Was Decede If Yes, speci			n? (Spe Puerto I	cify Yes or No- Rican, etc.)			k, White,	an Indian, etc.	
in 72 hours e. nan "natura Medical E	Completed		15. Deceder ecify only highe	nt's Education st grade completed)		(Gi	cedent's Usual ive kind of work DO NOT use	done du		of workii	ng	16b	. Kind of Bu			
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but a completely filled in by the funeral director.	by			ons contributing to d	8			_	en in Part I.						ne cause of d	
sician: The law re certificate has be irector, page 2 sh	Completed		L	, 0							1 🗌 Yes	psy ormed	?		psy findings mpletion of c	
nysician nis certif I directo	To Be	25. Was case referrexaminer? 1 Yes 2		Hospital:	Inpatient	2 🗆 ER/Outpa	utient 3 🗆 DO	Othe	ce of Death r: 4 Nur	`	only one) me 5 🗷 Resi	dence	6 🗌 Othe	er (Specify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to make the funeral director.	Certificate:	27. Manner of Deat 1 Natural 2 Accident 3 Suicide	th 5 Pendir Investi 6 Could	gation not be	th, Day, Ye		У		at Yes 2 🗆 N	10	28d. Describe					
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To the Hos vithin 24 hd To the Fund completely	Medical	(Check 2	2 Medical E 3 Certifying	xaminer: On the bas Nurse Practitioner	sis of exam	ination and/or in	vestigation, in n dge, death occu	ny opinior	n, death occ le time, date	urred at	the time, date	and pla the ca	ace, and due	e to the ca nanner as	use(s) and ma stated.	anner stated.
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10	0	<i>RE20</i> 31. Date filed (<i>Mon</i>	i Sa	Jadi ,	M	D · 10	65 No	rth	Pour	,7	Blug	1.5	k 100	ON	d 21	224
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28155 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 ไว้ 6:15 P M 30 Rode August Meredith Eagon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery 5114 Battery Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 XF Months Days Hours Min March Day Year 1938 74 Ohio Director 577-52-7609 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Bethesda 1 Yes 2 XNo Montgomery MD 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 20814 United States 5114 Battery Lane rral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify "natural", 3 XWidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Higher Education Professor of Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frend Eagon Hopwood Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jordan Rode / Son 5114 Battery Lane, Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 09/01/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp and Address of Tacilland Cremation Services M00982 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between shock, or heart failure. List only one cause on each line Onset and Death
1.5 years Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Melanoma Medical Examiner 6 years Malignant Melanoma Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Year Month Day Pregnant at time of death should be detached 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury Natural 5 Pending after death.

I Director: Af Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30 V

within 2

31. Date filed (Month, Day, 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifier

Linda M. Barrell, M.D.

State

Registrar

29c. License number

2370 University Blvd. #400, Wheaton, MD 20902

D35996

29d. Date signed (Month, Day, Year)

08/31/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 7:53 P Stephen August Rynas Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 415 Russell Ave. #1111 Gaithersburg Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct • 28 • 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months New New 1 🕅 M 2 🗆 F Days Hours Min 90 **Director** Oct. 053-18-9700 York Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 😾 No MD Montgomery Gaithersburg ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 415 Russell Ave. #1111 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Vas Deceden Evolution (NE) Vas 2 NE) NE 943-45 Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. W.W. II 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Writer Advertising Be Department of Health and Mental Hy Important: If item 27 is marked other any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillien Francis Rynas Hedwige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie E. Rynas / Wife 415 Russell Ave.,#Illl, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 08/29/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Adult failure to Thrive Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran: Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 se as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Yea Pregnant at time of death Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page performed certificate 2 No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ours after death.

neral Director: Aft
filled in by the fur 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State hin 24 hours a the Funeral D mpleted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

> Wikaliert Delsin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

04115

29d. Date signed (Month, Day, Year)

20877

August 27,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FH g941 7/19/13 TRT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ 2226 argare Medical 4a. Facility Name (if no institution, give street and number 4c. County of Death Examiner Medica Baltimore Bultimore If Under 24 Hrs. 8. Date of Birth 2/4/1941 Hours Min. (Month, Day, Telar) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Social Security Number Days 1 M 2 F 219-38-6598 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Baltimore 1 Yes 2 XNo Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a 21204 409 Virginia Ave Apt 403 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. ò 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify "natural", 3 XWidowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "I life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Nurse's Assistant Mercy Hospital na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Edith Capers James House Jr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2209 Deerfern Crescent, Edith House Foster-Sister Baltimore, Μd 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) King Memorial Park 9/8/2012 Woodlawn, Md Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Markand Adress of acility 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ancylo disease or condition Medical resulting in death) Due to (or as a conserue Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ō Month Year Day detached Yes 2 No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Loagulerpath 24a. Was an page 2 s autopsy has certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 40 1 Impatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred nla 1 Natural 5 Pending work?
1 Yes 2 No Ma Accident Investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 🗆 within 2 only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 1396069985 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place, 301 Saint Paul mrawi 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ amaust 23 11:00 AM 20/2 Adrian W. Rich Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Roland Park Place 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) **Director** 159-16-3008 1 M 2 D F 98 Yrs. Julv 18_1914 Virginia 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. n/a Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 830 W. 40th Street 21211 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 🔀 Widowed 4 🗌 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Business permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest A. Rich Alice Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Rich/ Son 619 Stoney Spring Dr. Baltimore, MD. 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-4-12 Hilltop Service Co. Towson, MD. 21. Signature of Funeral Sa 22. Name and Address of Facility Funeral Home, ice Lizarise 1050 York Rd. Towson, 23a. Part 1. Enter the clsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final argerios cleratic cardiavascular disease Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se's consequence or, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by effusion - cause unknown 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Roulure 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death heck only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

Di Babelle

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N IS ABELLE MACREGOR, 830 W-40th STREET, BALTIMORE, MD 21211

D13657

august 29,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma		artment of Healt		ntal Hygie	ne 2012	28159
		_	Registrar 1. Decedent's Name (First, Middle, La	est)	Cer	tificate of Deati		Reg	. No. 2 U 1 Z	To Time of Booth
ويعامر	Physicia Media	cal	CARRINA	STANLEY	/			Month 9	Day 12/2012	3. Time of Death
	Examir	ier	4a, Facility Name (if not institution, give	BILLIA		4b. City, Town, or Location			SALT IM	ORE
	Funeral Director			Sex 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hour	der 24 Hrs. 8 rs Min.	Date of Birth Month, Day Ye,	9. Birth	nplace (State or Foreign ntp) The Care lina
	aryland a-f show fied at	ector	10a. State 10b. County	A	Oc. City, Town or Loc	eation	-			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral Director	10e. Street and Number	1.6	Red	10f. Zip Code) }/	10g	. Citizen of What Cou	
	r death w		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No	er in U.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexic	Origin? (Specify ican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
-0036	ours afte atural", c cal Exam	eted b	3 Widowed 4 □ Divorced 15. Decedent's	If Yes, Give Year or Dates.	1	Yes 2 No Spec	cify:		Specify: B	ack
21215-0036	vithin liene. sr tha the N	Completed by	(Specify only highest g		(Give k	ent's Usual Occupation ind of work done during m NOT use retired)	nost of working	161	b. Kind of Business II	L Ama
Maryland	ge 1 and 2 should be filed wit it of Health and Mental Hygie If item 27 is marked other or other traumatic event, t	To Be	17. Father's Name (First, Middle, Last)	Prince		22.0	other's Name (F	irst, Middle, Maid	den Surname)	
	and 2 should Health and N tem 27 is ma		19a. Informant's Name/Relationship (19b. Mailin	g Address (Street and Nun	mber or Rural Ru	oute Number, City	y or Tow tate, Zip	Code)
Baltimore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		20b. Place of Dispos	sition (Name of atory or other place)	a la la	e 200	c. Location - City or T	own, State
Balti	permit. Page Department of Important: If any injury or once,		21. Signal of Funeral Service Licer	Gran	22	Name and Address 1 Fau	Juss 1	Funeral Ave.	Hone, P.	A. MO 21216
	Ph. sician/		23a. Pert 1. Enter the disease, or conshock, or heart failure. List only	plications that caused the cause on each line.	0 44	• 33	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a c	onsequence of):	() 2 /3				
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a c	onsequence of):					
_	ath certificate be executed attending physician and for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
3760	ficate t g phys as the l	Medic	555005	d						
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affact death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at til 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
Records, P.O.	uires that the dea n signed by the a ld be detached f	by	Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause given in Pa	art I.		co use contribute to t	
ords	v require s been si should	Completed	Н					1 ∐ Yes 24a. Was an		obably 4 Unknown
Rec	Physician: The law r this certificate has rral director, page 2 ?		25. Was case referred to medical	·				autopsy performed 1 Yes 2 Z	death?	ompletion of cause of
Vita	ysicia is certi directo	To Be	examiner?	Hospital:	2 ER/Outpatient	Other:	Death (Check on		e 6 🗆 Other (Specif	v)
Division of Vital	ending Pheath. Pr. After the Prefuneral	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigatio	28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury at work? M 1 \(\subseteq \text{ Yes} 2	28d	. Describe how in		
Divisi	al or Atters al safter de		3 Suicide 6 Could not to determined	28e. Place of Injury building, etc. (S	- At home, farm, stree Specify)	et, factory, office	28f.	Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director After this completed filled in by the funeral dir	Medical	(Check 2 \(\sum \) Medical Exam	iner: On the basis of exan	nination and/or investi	ocured at the time, date an gation, in my opinion, death eath occurred at the time, d	occurred at the	time, date and pla	ace, and due to the ca	use(s) and manner stated
	To t To t		29b. Signature and title of certifier	D		29c. License numbe		29d.	Date signed (Month,	Day, Year)
			30. Name and address of person who L. Ali Bon	SECOURS H	ospital 2	int) Loop W. Ba		e St.	Baltimore	MD 2/223
	Stat Registra	_	31. Date filed (Month, Day, Year) SEP 0 5 201	2 2. Registrar's	Signature face	W				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #7, per fh. g931 9-7-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 Day 01 Mardee Year L. Schickling 52 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death of Marylond Medical Center Baltimore University N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Nov. 06 1948 195-40-8910 Director PA 1 □ M 2 🗶 F 63 Yrs Usual Residence of Decede or 28a-f shov s notified at show 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 21122 USA 8263 Camion Court Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Was Deceue... Armed Forces? → Yes 2 X No 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Anne Arundel County Schools 12 Computor Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Baughman Anna Donald Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Eugene K. Schickling 8263 Camion Court, Pasadena, MD 21122 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 04 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Metro Crematory Inc. Baltimore, MAryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadéna, MD 21122 23a. Part 1. Enter the disease, or comp shock, or heart failule. List only or cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, because on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) for as a consequence of Examiner Intraabdomina Sequentially list conditions, if any, leading to immediate case. Enter Underlying Examine Due to (or as a consequence of attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.b. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached t 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 \square Pending iniury 1 Yes 2 No M Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Dav. Year) mo. 127362 92400 NP 9 122 of person who completed cause of death (Item 23a) (Type, Print) 22 J-breene Bulhmore 21210 PyronHKA MO 32. Regis rar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month Day DCS 10:04 BM 2012 4a, Eacility Name (if not institution, give street and number) Examiner 4c. County of D andallstown ltimore 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 1 □ M 2 🗹 F 6 or then "netural", or itams 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. Cit Town or Location Director 10d. Inside City Limits som ithac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21207 1802 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours efter 1 ☐ Yes 2 ☐ No Specify: Completed 3 ₩Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) condary (0-12) omesti Be other treumetic event, parmit. Pege 1 and 2 should be filed Dapertment of Health and Mental Hy Important: If Item 27 is merkad otheny injury or othar treumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ omith tdelai Informant's Name/Relationship (Type, Print) 19b. Mailing Address GWYNN Baltimore, 20a. Method of Disposition 20b. Place of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Stage Onset and Death Priysician Dementia nel disease or condition resulting in death) Medical Due to (or as a consume nce of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): physician end s tha burlai-trensit or Attanding Physicien: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 es that ate has baen signed by the ettending page 2 should ba deteched for usa es IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No **Division of Vital** completaly filled in by the funaral diractor. 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specify) 1 Yes 2 🗆 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Diractor: At 1 🗆 Yes 2 🔲 No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗍 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only c 29b. Signatur and title of certifie D0053337 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 6934 uten-a Glen Burnie Mo Aviation levara 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

12-06621 Eddie Smith

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2012 28162

		1- For State Certificate C	of Death	Reg.	No.	
Physic Medical Exam				2. Date of Death	av Year	3. Time of Death 0704 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth (MM/DD/YYYY) 9. Birti	pplace (State or
Director		220-80-0040 1 M 2 F 49 Y	Months Days Hours Min.	`	1 Teoreign	
тапу .		10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ᅙ	MD Baltin	none			1 Yes 2 No
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Director	1334 E 25th Street, Apt. 1	10f. Zip Code	10g.	Citizen of What Coun	try?
death wit	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. W. Armed Forces? If Yes 2 No	fas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
s after ral", o	by	3 Widowed 4 Divorced II Yes, Give Year 1 or Dates:	Yes 2 No specify:		Specify: B	ack
2 hour "natu I Exan	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of womost of working life. DO NOT use retire	vork done 16 red)	Sh. Kind of Business/Ir	odustry 5 i + y
10re, MD 21215-0036 sees I and 2 should be filed within 72 hours at nt of Health and Mental Hygiene. 1: If item 27 is marked other than "natural other traumatic event, the Medical Examin	Completed	17_Father's Name (First_Middle, Last)	1100		Hospi	tal
21215-00 uld be filed wit Mental Hygien marked other c event, the M	BeC		Shi Cl	(First, Middle Maid	den Surname)	
D 2121 should be fi and Mental 7 is marked	흔	19a, Informant's Name/Relationship (Type Print)	ng Address (Street and Number or R	tur Joute Number	r, City or Town, State,	Zip 297,15
ore, MD ss 1 and 2 sho of Health and If item 27 is		Shirley M. Smith (Mother) 360 20a. Method of Disposition 20b. Place of Dispo	I Fords Ln, Application (Name of cemetery,		Salto, Y	own, State
Baltimore bernit. Pages 1 a Department of He important: If it njury or other t		1 Burial 2 Cremation 3 Removal from State crematory or o	therolace)		Nindsor A	1:11, mD
Baltimo permit. Page Department Important:		21, Signature of Funeral Service Licentee	Name and Address of Facility ee	ne Fun	eral Sen	vices
Physician		23a. Part I. Epte the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Cardiomegaly with	the mode of dying, such as cardiac or biventricular d	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. 1eft ventricular hypothemic of the condition resulting in death) Due to (or as a consequence of):	ertrophy			Death
100		Sequentially list conditions, b.				
	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.				
Scuted and transit		events resulting in death) Last Due to (or as a consequence of): d.				
S 8 8	Medical	▼ UNPENDED	g931 9-20-12 sm			
	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ectopic pregnar	- 1	23d. Date of delivery	V
Box 687 death certific the attending of	Physician/	past 12 months? 1 Yes 2 No 9 Unknown a Unknown	etal death 3 Ectopic pregnar ther (Specify)	icy	Month Da	y Year
b.O. Be that the des ned by the a detached fo	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ires that the signed by I be detach	d by				No 3 Proba	
Records, The law require fificate has been si	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
tal Rec	S			performed 1 Yes 2	death? No 1 ✓ Yes	2 No
Vital hysician: this certi	B	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check or 3 DOA Other Nursing		idence 6 Other:	-
of \ing Phy	7: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of		28d. Describe how		
Division tal or Attendia as after death. al Director: A	catio	2 Accident Investigation	1 Yes 2 No			
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	et, factory, office building, etc.	28f. Location (Stree or Town, State)	et and Number or Rura)	Route Number, City
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certification or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it.	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurone) 2 Medical Examiner: On the basis of examination and/or investigation.	rred at the time, date and place, and c tion, in my opinion, death occurred at	due to the cause(s) the time, date and	and manner as stated	cause(s)
vit wit	₩ W	and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	n, Day, Year)
		(Xarlakely)	O.C.M.E.	S	eptember 3, 201	2
P		Name and address of person who completed cause of death (item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Ba	altimore Street, Baltimore. M	D 21223		
		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	SEP 0 5 2012 Cener & Saver				

DHMH 17 Rev 1/2001 OCME 2006

OCME

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AMEND ITEM#17perFH, G931, 975/2012, WS
State of Maryland 7 Department of Health and Mental Hygiene Reg. No. 201 28163 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Joyce Shirriel August OM 201 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner N/A Samer timore itan ge (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Min. Months Hours (Month, Day, Yea 8 / 8 / 1 9 4 Country) 218-44-0939 64 Yrs Director MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No N/A Baltimore MD 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 501 E. 21202 USA Preston St. Apt. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) 11th College (1-4 or 5+) Disabled N/A Be Samuel Ful Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of Department of Health and Menta Important, If item 27 is marked any injury or other traumatic and once. 2 irriel-Husband Virginia Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 E. Preston St. Apt.123 Balto., MD 21202 Michael Shirriel-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Site Crematory 8/17/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) On Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East No My Ran 1101 E. North Ave. Baltimore, MD 21202 Dio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner DIJease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by eato 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 2 40 1 🗌 Yes 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 No 1 Yes |은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of 28c. Injury at work? Certificate: 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Contrying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George, Starkes 2340 PM September 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Mountand Modical Conter Backmore NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Hours Director 218-84-6176 XXM2□F 48 03-07-64 MD 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3837 Clifton Avenue 21216 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces Black, White, etc. African 9 þ 1X Never Married 2 ☐ Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XX No Specify: Specify: American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12th Grade NA Truck Driver Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I မ Bevlev Lee Starkes Edith Starkes I and 2 should b I Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Carter-Sister 3004 Windsor Avenue Baltimore, Maryland 21216 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State . Page 1 permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 09-05-12 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Prevmonio Medical resulting in death) Examiner Pontine Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide 2 🗌 No Investigation 24 hours after deau Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete only one) 29b. Signature and title of certifie 29c. License number RES 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coreene Street, Baltimore, maryland 21201 22 Kestler 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Cina	artment of Health and Mental	Hygiene Reg. No. 2012 28165
Physicia Medic		Decedent's Name (First, Middle, Last) ALICE SWIFT	2. Date Month Sep 1	
Examin		4a. Facility Name (if not institution, give street and number) ROLAND PARK PLACE	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death BALTIMORE CITY
Funeral Director		5. Social Security Number 219-18-2886 Usual Residence of Decedent 6. Sex 1	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. June	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country) 9. ARYLAND
laryland 3a-f show iffied at	ector	10a. State 10b. County 10c. City, Town or Lo	cation Baltimore City	10d. Inside City Limits XX Yes 2 □ No
with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 830 W. 40th St.	10f. Zip Code 21211	10g. Citizen of What Country?
Ind 21215-0036 filed within 72 hours after death with the Maryland and Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XX Nover Married 2 □ Married 1 □ Yes XX Nover Married	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc	
21215-0036 within 72 hours after ygjene. her than "natural", o her tha Medical Exam	e Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. (Give life. L N/A Secr	dent's Usual Occupation kind of work done during most of working O NOT use retired) etary	16b. Kind of Business/Industry Epiphany Lutheran Church
Maryland 12 should be filed 14th and Mental Hy 27 is marked oth	To Be	17. Father's Name (First, Middle, Last) Thomas Swift	18. Mother's Name (First, Min Dorothy Smit	
re, Maryland 212 1 and 2 should be filed within 1 land 2 should be filed within if health and Mental Hygene, if marked other than other traumatic event, the n		Michael Stanley (PR) 100	ng Address (Street and Number or Rural Route Nu N. Charles St. Baltimon	imber, City or Town, State, Zip Code)
Page nent cant youry or			sition (Name of Date natory or other place) Park Cem. 9-7-2012	20c. Location - City or Town, State Baltimore, Md.
Balt permit. Departr Import any inji			Name and Address of Facility Lassahr Ol Belair Rd. Baltimo	n Funeral Home re, Md. 21236
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		ry arrest, Approximate Interval Between Onset and Death The Arba
Medical Examiner		resulting in death) Due to (or as a consequence of):		, 500
outed	camine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events		
te be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of): d.		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 5 1 1 1 1 1 1 1 1	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
S, P.O.	d by Pł	Part II. Other significant conditions contributing to death but not resulting in the Legislation with the conditions will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contributing to death but not resulting in the Legislation will be a contribution will be a contributi	nderlying cause given in Part I. 23e. (Did tobacco use contribute to the cause of death?
fital Records, sician: The law requires certificate has been signirector, page 2 should b	Completed by	Heypersensure Distribus con disease		Was an 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Vital Rec hysician: The la nis certificate he il director, page		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check only one)	
on of V nding Phys ath. : After this e funeral di		27. Manne Death 1 V Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury		Residence 6 Cother (Specify) ibe how injury occurred
Division Hospital or Attendin 24 hours after death. Funeral Director. After	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
Division or the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation on the basis of examination and/or investigation of the basis of my knowledge only one)	igation, in my opinion, death occurred at the time, d	ate and place, and due to the cause(s) and manner stated.
To # withi		29b. Signature and title of certifier Nabelle The Gregor M3	29c. License number	29d. Date signed (Month, Day, Year) Sep Jewber 4, 3012
6		30. Name and address of person who completed cause of death (Item 23a) (Type, F TBBELLE NBEGREGOR, 830W-4	oth STREET, BALTITOR	(E, 079 21211
State Registra	-	31. Date filed (Month) Day, Year) 32 reistrar's Signature.	Mes	

DHMH 17 Rev 06-2011

2-06446		Please Type or Print in Black Indelible Ink. E			gible.	
larry Strateme	yer	State of Maryland / Department of Heal		lygiene	001	0 0016
		1- For State Certificate of Deat	h		eg. No. 201	2 28 6
Physic		Decedent's Name (First, Middle,Last)		Date of Deat Month	Day Year	3. Time of Death
∕ledical Exam	linei	natty inecacte Stratemeyer,	Enter the second	August 26		2215 hrs
		St. Joseph Medical Center Tows	Town, or Location of Death	1	4c. County of Death Baltimore Cou	
Funeral	-		er 1 Year If Under 24Hrs	R Date of Birt	h(MM/DD/YYYY) 9. Bir	•
Funeral Director		Month		1.	Foreig	ın
	ĺ	214-86-3712 1 M 2 F 45 Yrs. Usual Residence of Decedent		10/21	./1966 cº	^{untry)} Netherlands
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
. ≜	L	MD Baltimore Hunt Valley				1 Yes 2 No
Maryland 28a-f shnw 1 at once.	5	MD Baltimore Hunt Valley 10e. Street and Number 10f. Zip	Code		g. Citizen of What Cour	ntry?
th the Maryland 23a nr 28a-f shn notified at once.	Director	10104 Modelpha Drive Ant D	1021			,.
hours after death with the Maryland "natural", or items 23a nr 28a-f shn Examiner must be notified at once	<u></u>		1031 ent of Hispanic Origin? (Sp	pecify Yes or No-	U.S.A.	can Indian, Black,
eath vitem	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specif	fy Cuban, Mexican, Puerto		White, etc.	out maran, black,
fter d	F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify:		Specify: Wh:	i te
ours a atura camin	d b		Occupation (Give kind of v		16b. Kind of Business/I	
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of wor	rking life. DO NOT use reti	ired)		
vithin ene.	Ę	12 Office In	nstaller		Office Fu	rniture
21215-0036 Mote of filed within 72 hours after the state of the Mote of the state o	ပြ	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, M	laiden Surname)	
121 d be f ental arked	B B	Harry Theodore Stratemeyer, Sr.	Elisabe	th	Hellebrand	
should Mark Mark	유		(Street and Number or F			
MD and 2 sho salth and 2 sho sm 27 is		Donna Stratemeyer / Spouse 2312 Cheta 20a. Method of Disposition 20b. Place of Disposition (Name	wood Circle,	Apt. 30	01, Timoniu 20c. Location - City or	
Ore, es!a of He Lite		1 Burial 2 Cremation 3 Removal from State crematory or other place)		Date	20c. Location - City or	rown, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 77 Department of Health and Mental Hygiene. Impurtant: Witen 27 is marked inther than injury or other fraumattic event, the Medical injury or other Traumattic event, the Medical		4 X Donation 5 Other Spedify: Anatomy Gifts Re		29/2012	Hanover, M	aryland
Salf ermit Separt mpnr njury					Gifts Regi	
_		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	onnelley Dr.			
Physician /Medical		failure. List only one cause on each line.			st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovas	cular Disea	se		Death
Andre		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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ed 1sit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
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ox 68760, ath certificate be exattending physician or use as the burial	ğ		JZ 10-10-12	эш		
Box 68760, c death certificate be the attending physic ed for use as the bur	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	incv	23d. Date of delivery Month D	ay Year
x 61 h cert endin use a	cia	past 12 months? 4 Pregnant at time of death 5 Other (Spec		iii Cy	Month	ay real
BO) e deat the at ed for	nys	1 Yes 2 No 9 Unknown 9 Unknown				[
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, P.C ires that signed b	d by			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
cords law requir has been s	lete			24a. Was a autops		opsy findings available ompletion of cause of
e law te has ge 2 s	Completed			perform	ned? death?	
Division of Vital Records, tale or Attending Physician: The law require an ablanceor. After this certificate has been sited in by the funeral director, page 2 should b		25. Was case referred to medical 2	26.Place of Death (Check of		No 1 ✓ Ye	s 2 No
/ita	Be C	examiner?		, ,	Residence 6 Other:	
of \ ing Phy After th	 10	27. Manner of Death 28a. Date of injury 28b. Time of Injury 2			ow injury occurred	
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riSic rAtte er de: recto	lica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory,	office building, etc.	28f. Location (St	reet and Number or Run	al Route Number, City
Divis pital or At ours after d teral Direc	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta		
Divisior Hospital or Attend 24 hours after death Funeral Director:		29a. Certifier , Cartifician Physician. To the heat of my knowledge, death accurred at the	time, date and place, and	due to the cause	(s) and manner as state	d
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my				
To No.	Š	and manner stated. 29b. Signature and title of certifier 29c.	License number		29d. Date signed (Mon	th, Day, Year)
		(0/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	O.C.M.E.		August 28, 2012	
		30. Name and address of person who completed cause of death (Item 23a)				
			e Street, Baltimore,	MD 21223		
S	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature				
Regis		SER 0 5 2012 August & Barel				
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OCME 2006		ONIOMAL				Not the College

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Brent Steele August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death <u>Atlantic General Hospital</u> Berlin 7. Age (In vrs. last birthday) If Under 24 Hrs. Funeral 8. Date of Birth 1 X M 2 🗆 F Months Days Min. Hours Director 217-50-0309 63 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code Funeral 9229 Bellbeck Road 21234 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 X Divorced permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 4 Stock Broker Be 17. Father's Name (First, Middle, Last) ည William Barthel Stokes Steele Grace 19a. Informant's Name/Relationship (Type, Print) Susan Brookes / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 09/05/2012 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No the 9 Unknown q Unknown s been signed by t should be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a, Was an has page performed certificate Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: ဂ္ 1 Inpatient 2 FR/Outpatient 3 IDOA this Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending n 24 hours after death.

le Funeral Director: Afte bleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier (Check only one) 29b. Signature a d title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print)

2012 A^M 1:54 4c. County of Death Worcester 9. Birthplace (State or Foreign 10/07/1949 Maryland 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Specify. White 16b. Kind of Business Industry Financial 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 Isle Verde Way, Palm Beach Gardens, FL 33418 20c. Location - City or Town, State Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, Md 21076 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 08/ SEP 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

			Plea	se Type or State o		n Black I I and / Dep					-		_	ible.		
	-	For State Registrar		Otato	or ivial yie		rtificat			alla iv	icinairiy	Reg. N	0.0	112	28	8168
Physiciar Medic		1. Decedent's Nam Michael	G. Sper	a							2. Date of De Month Septer	D.	ay 3. 2	Year 2012		of Death
Examine	er	4a. Facility Name (iii Medstar		give street and nun ery Medio		nter	4b. City Oln		Location of	of Death			c. County	of Death Om∋ry		
Funeral Director		5. Social Security N 267–11–5	lumber	6. Sex 1 X M 2 \square F		s. last birthday)	1	er 1 Year	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Aug 2	rth			lace (State	e or Foreign
and show I at	or	Usual Residence 10a. State	of Decedent 10b. County		10c.	City, Town or Lo	cation							1	0d. Inside	City Limits
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ter o	ρ	11. Marital Status 1 【XNever Marital Status 1 ■ Wildowed		12. Was December of Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 X No /e		f Yes, spe	cify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe	cify Yes or No Rican, etc.)		Blac	e - America k, White, e	etc.	
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d 2 should alth and N 27 is ma er trauma		19a. Informant's N. John Spe	ame/Relationshi	p (Type, Print) her		19b. Mailii 4302	ng Addres Mari	s (Street a	St.	r or Rura Rock	Route Numb Ville,	er, City o	r Town, S 20853	tate, Zip C	ode)	
Page 1 an nent of He ant: If item ary or othe				3 ☐ Removal from	State	Place of Disponder Cemetery, crer	natory or	other plac	_{e)} atory		Oate 07/12			City or To		
permit. Departr Imports any injt		21. Signature of Fu	ineral Service Lie	cerisee Me	M	01251 Be	Name a Ding everl	nd Addres Home v L	s of Facility Crem Heck	atio rott	n Servi	ice . Cl	P.O.	. Boc	784 . MD	21029
Physician/ Medical Examiner		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	(Final	a		ARCENO					r respiratory a	rrest,			Approxim Interval B Onset and	letween
be executed sician and burial-transit	ical Examiner															
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?		Birth 2 Finant at time	etal death 3	Ectopic Other (s		у				23d. Dat Mor	e of delive	ry Day	Year
ires that t signed b Id be deta	<u>م</u>	Part II. Other signi		ns contributing to d		resulting in the ເ	inderlying	cause giv	en in Part I	l.				ibute to the		f death?
sician: The law requ certificate has beer lirector, page 2 shou	Completed	HEN	notho.	RAX							24a. Was auto perfi 1 \sum Yes	psy ormed?	p	Vere autop rior to con leath?	npletion of	s available f cause of
ician: T	a	25. Was case referr examiner?		Hospital:				26. Pla	ace of Deat	th (Check		2 2 11				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	cate: To	1 ☐ Yes 2 ☐ 27. Manner of Deat 1 ☐ Natural 2 ☐ Accident		28a. Date (Mon		ER/Outpatier 28b. Time of injury		28c. Injury work	4 ∐ Nu rat	2	me 5 Resi 28d. Describe					
al or Atter s after des il Director ed in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determin	ot be 28e. Place	of Injury - At ng, etc. (Spec	home, farm, str	eet, factor	y, office			28f. Location (City or To			er or Rural	Route Nun	nber,
the Hospit nin 24 hour the Funera npletely fills	Medical	(Check 2 only one) 3	Medical Ex Certifying I	Physician: To the b aminer: On the bas Nurse Practitioner	sis of examina	tion and/or invest	tigation, in death occ	my opinio curred at th	n, death oo he time, dat	curred at	the time, date	and place	e, and due	to the cau	se(s) and n	nanner stated.
with Con		29b. Signature and					1	c. License 7 2 3 (630			581	76 M	(Month, D	4, 2	
51		30. Name and addr	J.MA	10, mp		FREA	Crint)	t Rei	no is	213	GALTH	ERS	BURB	, me	1 20	877
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DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at	Once
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Division of Vital Records, P.O. Box 68760	ospital or Attending Physician: The law requires that the death certificate be executed hours after death	fter this cert	illed in by the funeral director, page 2 should be detached for use as the burial-transit	

Funeral Director

	1	For State Registrar	Otate of f	viai yiai i		tificate of		und iv	iontai i iy	Reg. No.				
Physicia		Decedent's Name (First, Middle, La Nichole Rose St.	ast) nith						2. Date of De Month August		y 2012	ar	3. Time of Death 10:15 PM	
Medic Examin		4a. Facility Name (if not institution, give)		4b. City, Town,			August	4c.	County of D	eath		
		23820 Woodfield 5. Social Security Number 6.		Age (In yrs. Ia	st hirthday)	Gaithe			8. Date of Bir		Montgo		Y ace (State or Foreign	
Funeral Director		215-27-6895	1 □ M 2 🏋 F	22	Yrs.	Months Days		Min.	(Month, Da Feb 6,	y, Year)		Countr		
show d at	į	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc							10	d. Inside City Limits	
r 28a-f notifie	Sirec	MD Montgom 10e. Street and Number	ery	Gait	hersbu							\perp	1 AYes 2 □ No	
s 23a o	Funeral Director	23820 Woodfield	Road			10f. Zip Code 20882				10g. Citizen of What Country? USA				
or item niner m	by Fur	11. Marital Status 1 ☒Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 Yes 2	?		Vas Decedent of Yes, specify Cub	Hispanic Ori oan, Mexican	gin? (Spe ı, Puerto l	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
ural", c		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	A NO	1	☐ Yes 2 X N	o Specify:			Specify: White			9	
n "nat Medica	Completed	15. Decedent's (Specify only highest g	rade completed)	5.)	(Give F	lent's Usual Occu kind of work done O NOT use retired	during most	t of workii	ng	16b. Ki	ind of Busine	ss/Indu	stry	
ygiene her tha it, the l		Elementary/Secondary (0-12)	College (1-4 o	r 5+)		Worked	1			N/A	A			
lental H rked ot lic ever	To Be	17. Father's Name (First, Middle, Last) James S. Smith					ł		e (First, Middle, olter	Maiden S	Surname)			
lith and M 27 is mai r traumat		19a. Informant's Name/Relationship (Coleen Graf-Smit			19b. Mailin	g Address (Stree) Woodfi	and Numbe	er or Rura L. Ga	Route Numbe ithersk	r, City or	Town, State, MD 2	Zip Co 0882	de) 2	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from Sta	to C6	emetery, crem	sition (Name of natory or other pla	emator		Oate /05/12		ocation - City			
Departme Importar any injur once.		21. Signature of Funeral Service Licer		_ MO12	GC GC	Name and Addr	ess of Facilit	- atio	n Servi	ce	P.O. 1	Вох		
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physici s the bu	Medical		d											
been signed by the attending physician and should be detached for use as the burial-transit	₹ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live Birth 4 Pregnant	n 2 🗀 Fetal	death 3	Ectopic pregnar Other (specify)	псу			:	23d. Date of Month	_	/ lay Year	
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signed I be de	≦	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cause g	iven in Part I	l.					cause of death?	
should	ompleted								24a. Was	an	24b. Were	autops	y findings available	
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within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Exam	ysician: To the best on niner: On the basis of rse Practitioner: To	examination	and/or investi	igation, in my opir	ion, death oc	curred at	the time, date a	ınd place,	and due to the	ne caus	e(s) and manner stated.	
with.		29b. Signature and title of certifier	V	_		29c. Licen:					e signed (Mo tember			
1 🗸		30. Name and address of person who G. Coleman, M.D.					e, MD	2085	0					
State Registra		31. Date filed (Month, Day, Year)		trar's Signati	-	arkel								
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		State of Maryland / Depart					
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Physic	an	1. Decedent's Name (First, Middle, Last)	Mon	nth Day Year			
/Medi			N & S C	Hember 62 2012 /648 M			
Examir	er		**	4c. County of Death			
			Baltimore If Under 1 Year If Under 24 Hrs. 8, Dat	e of Birth 9. Birthplace (State or Foreign			
Funeral Director		226-56-7255 1 M 2x F 74 Yrs.	Months Days Hours Min, (Mo	ril 1,1938 Kentucky			
		Usual Residence of Decedent	Ap	111 1,1950 Rentucky			
ylane how	_	10a. State 10b. County 10c. City, Town or Locat	tion	10d. Inside City Limits			
e Ma Ba-f s ified	5	MD Baltimore	E	dgemere 1 □ Yes 2% No			
e not	Director	10e. Street and Number	10f. Zip-Code	10g. Citizen of What Country?			
ath w s 23a ust b		7311 Waldman Avenue	21219	United States			
er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Wa	s Decedent of Hispanic Origin? (Specify Ye es, specify Cuban, Mexican, Puerto Rican, e	s or No- atc.) 14. Race - American Indian, Black, White, etc.			
is after sold after a second and a second a seco	by F	1 ☐ Never Married 2 🕱 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Yes 2. ■ Yes 2. Specify:	Specify: White			
Z I Z I S-UUSO u within 72 hours aft giene. r than "natural", or the Medical Examir			nt's Usual Occupation	16b. Kind of Business/Industry			
nin 72 n' "na n' "na fedio	Completed	(Specify only highest grade completed) (Give kir.) Elementary/Secondary (0-12) College (1-4 or 5+)	nd of work done during most of working NOT use retired)				
d with	Ĕ	6 Years Home	emaker	Own Home			
othe file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Surname)			
If yial Id Z Z D-UU30 should be filed within 72 hours after death with the Maryland ad Mental Hyglene. marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	<u>ام</u>	Oscar Clark	Bonnie G	arrison			
Maryia d 2 should I th and Meni th and Meni 77 Is marked traumatic e	ga - {	1	Address (Street and Number or Rural Route				
< 0 ± 0 ±				imore, Maryland 21215			
Dallimore, permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other	l i	TES Durial 2 Cremation 3 Periodal noni State	tory or other place)	20c. Location - City or Town, State			
Dalitimor Department of Important: If it any Injury or o		Donation 5 □ Other (Specify) 21. Simplyre of Funeral Service Licenses Denn S C 750 1 22. N	1 Mem. Gdns. 9/6/201	2 Middle River, MD			
Dalti permit. Departn Importa any Inju		Du	Name and Address of Facility da—Ruck Funeral Home	e of Dundalk, Inc.			
- 20= 00		29a. Part +: Enter the disease, or complications that caused the death. Do not enter	922 Wise Ave. Dunce	dalk, Maryland 21222 iratory arrest, Approximate			
	Y Y	shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death			
Physician // Medical		disease or condition resulting in death) a. Due to (or as a consequence of)	Embolism				
Examiner		Due to (or as a consequence or)					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
fted I ansit		Cause (Disease or injury that initiated events c					
be executed sician and e burial-transi	m	resulting in death) Last Due to (or as a consequence of):					
0 00 0	lical	d					
ntifica ng ph	Mec	IF FEMALE:					
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy	23d. Date of delivery Month Day Year			
he dea the at ched f	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)				
d by t		Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I. 23	Be. Did tobacco use contribute to the cause of death?			
VICAL THE COLUS, F.O. BUX 00 V sician: The law requires that the death certificate certificate has been signed by the attending physicactor, page 2 should be detached for use as the	d by			1 Yes 2 No 3 Probably 4 Unknown			
v requires been sign should be	Completed		24	a. Was an 24b. Were autopsy findings available			
has t	Ę			autopsy prior to completion of cause of death?			
VICAL clan: Th ertificate ector, pa	ပိ	25. Was case referred to medical	26. Place of Death (Chec	☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No k only one)			
sicerti direct	P B	examiner? 1 Yes 2 Floor	Other:	☐ Residence 6 ☐ Other (Specify)			
g Physer this neral d		27. Manner of Death 175 Natural 28a. Date of Injury 175 Natural 175 Natural 175 Natural 175 Natural 175 Natural 175 Natural	28c. Injury at Work?	escribe how injury occurred			
tending leath. or: After the fune	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm, street building, etc. (Specify)		cation (Street and Number or Rural Route Number, y or Town, State)			
italo ursaf ral Di		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
Hosp 24 hou Fune rtely fi	<u>2</u>	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 2 Medical Examiner: On the basis of examination and/or investigation one) 2 Medical Examiner: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one) 1 Certifying Physician: To the best of my knowledge, death of check only one check only one check only one check on the check of check of check on the check of check on the check of check of check of check of check on the check of					
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
F S F O		· Mac MD	1326306168	Sentember 12 2012			
, \		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr		To chi e in Dei Od a do			
H		MATHEN SINGLETON		rn Avenue, Baltimore, MD, 21224			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 5 2012	1				
Regist	rei!	OFLA A FAIT CONTENT IS IN					

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OB Physician/ Scroggins 1725 Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University land Medical Conter Year If Under 2 Age (In yrs. last birthday)
83 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 215-24-4391 Months Hours Min (Moth Pay2 7ar) **Director** 1928 Maryland 1 □ M 2 🔀 🗗 Usual Residence of Decedent and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 shov
raumatic event, the Medical Examiner must be notified at or 28a-f show Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1116 Bonaparte Avenue 21218 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2-No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 📈 No 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Facility Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Roland Goynes Nancy Mils 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trianda Goldsboro /Daughter 27 1116 Bonaparte Avenue Baltimore, MD 21218 Department of Health Important; If item 2 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date of 02 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. NanGaramatricon Fand Funeral Alternatives M0144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Multiple Due to (or as a consequence) disease or condition System Failure Medical resulting in death) **Examiner** Preumonio week Aspiration Sequentially list conditions, Be Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury for as a consequence of burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 attending | use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No 2 🗌 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) ည 1 Yes 2 No Other: 1 Anpatient 2 ER/Outpatient 3 DOA ne Hospital or Attending Physin 24 hours after death.

Funeral Director; After this optetely filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 only one Certifying Nurse Practitioner To the best of my knowledge, death 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 102297 8/31/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V South Greene Street Beltimore Maryland 22 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O'Bh 30^{pay} 20^{ra}2 9:20a.M Hortense Spell Theresa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 1133 North Carey Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Birthplace (State or Foreign Country) Days Hours Min 218-18-7158 **Director** 1 □ M 2 1 F 20 92 Yrs MD Usual Residence of Decedent show i Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 X Yes 2 ☐ No NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 U.S.A. 1133 North Carey Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ል Specify: Black Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Janitress 8th grade Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hwimportant: If them 27 is marking highly or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Harcum Lindzy Nickings 19a. Informant's Name/Relationship (Type, Print) 19b Majling Address (Street and Number or Bural Route Number City of Town, State Zip Code 1133 North Carey Street, Baltimore, Md 21217 William Davis-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 9/12/2012 Owings Mills, Md 21. Signature of Puperal Service Lin March For H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Unset and Death Immediate Cause (Final Physician STWC disease or condition Medical resulting in death) Due to (or as stonsequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last 124 hours after death.

Funeral Director: After this certificate has been signed by the attending physician letely filled in by the funeral director, page 2 should be detached for use as the burla Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? 2/X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D33400 08/30 12012 address of person the completed cause of death (Item 23a) (Type, Print) 6301 N Charles ST Battimore MD 21212 31. Date filed (Month, Day, Yand State Registrar

9. 20 cm

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State C	of Maryland / Dep Ce	artment of I rtificate of I	Health and Death	Mental Hy	giene 20	12 28173		
	Physicia Medic		Decedent's Name (First, Middle, Last) Frede	rick Simmons			2. Date of Dea		3. Time of Death 7:15 P M		
0	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatt 1222 Perryman Road, Apt. 208 Aberdeen				th 4c. Cou		Death Harford		
	Funeral Director		5. Social Security Number 124-24-6196 Usual Residence of Decedent	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h 1 192 8	9. Birthplace (State or Foreign Context York		
	Maryland 28a-f shov otified at	Funeral Director	10a. State 10b. County Harford	10c. City, Town or Lo	ocation	Aberdeen			10d. Inside City Limits 1 Yes 2 □ No		
	with the s 23a or ust be n	eral D	10e. Street and Number 1222 Perryman Road, Apt. 208		10f. Zip Code	21001		10g. Citizen of Wh	at Country? USA		
9800	ırs after death ural", or item Il Examiner m	by	Armed Fo	orces? 2 Army	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puert	oecify Yes or No- o Rican, etc.)		American Indian, White, etc. Black		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(Give	dent's Usual Occup kind of work done OO NOT use retired) Truck	during most of wor	king	16b. Kind of Busin	ness/Industry		
		To Be	17. Father's Name (First, Middle, Last) Samuel Sin	ımons		18. Mother's Na		Maiden Surname) ee Williams			
			19a. Informant's Name/Relationship (Type, Print) Donna Lynn Simmons / Daughter					r, City or Town, Staten, MD 2100			
		İ	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place of Disponentery, cre Chesapea	osition (Name of matory or other place nke Cremator	ce) y 9/:	Date 5/2012	20c. Location - Ci	ity or Town, State		
			21. Signature of Funeral Service Licensee Dorota Marshall		2. Name and Addre Maryland Cre		rices, PO Bo	ox 1413 Balti	more, MD 21203		
	Physician/ Medical Examiner			caused the death. Do not ent ich line. (or as a consequence of):	er the mode of dyin	g, such as cardiad	or respiratory arm	est,	Approximate Interval Between Onset and Joseth		
on of	ate be executed bhysician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events C	(or as a consequence of):							
Box 687		Σ∣	in the past 12 months?		Ectopic pregnand Other (specify)	ЭУ		23d. Date o	•		
ls, P.O	uires that the signed by alld be detact	ed by Pr	Part II. Other significant conditions contributing to d	eath but not resulting in the I	underlying cause giv	ven in Part I.	23e. Did to		ite to the cause of death?		
Division of Vital Records, P.O.	sician: The law requires certificate has been sig irector, page 2 should b	Completed					24a. Was a autop perfor	sy prio med? dea	re autopsy findings available or to completion of cause of th?		
tal	ysician: is certific director,	Be	25. Was case referred to medical examiner?			ace of Death (Che					
of V	r this eral dii	은 .	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing 27 Manner Death 28a, Date of injury 28b, Time of 28c, Injury at					Home 5 Presidence 6 Other (Specify) 28d. Describe how injury occurred			
sion o	ttending F death. stor. After y the funer	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No								
Divis	Hospital or A 24 hours after Funeral Directely filled in by		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	the the	Med	only one) 3 Certifying Nurse Practitioner	sis of examination and/or inves	stigation, in my opinion, death occurred at t	on, death occurred the time, date and p	at the time, date ar	nd place, and due to	the cause(s) and manner stated.		
	5 ¼ € Ø		29b. Signature and title of Ceptifier	md	29c. License	70658	27	29d. Date signed (N	Nonth, Day, Year)		
	10		30. Name and address of person who completed cause Alogoe Cillon 50	e of death (Item 23a) (Type, I	Chesa	peake	Or.	Belai	, MD 21014		
	Stat Registra		31. Date SEP 015 2012 Several	egistra s Signature		1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 51PM Tenevieve : 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore as ouse If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Days Hours Min Maryland 0271471916 96 Director 13-01-2669 Usual Residence of Decedent 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 XYes 2 No Maryland Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21227 3308 Benson Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturer Seamstress 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Bieda George Buczkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120-L West Broadway Bel Air, Maryland 21014 Francis Smidt - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Saint Stanislaus Cemetery 09/08/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber
401 S. Chester 21. Signature of Funeral Funeral Homes P.A. Street Baltimore, Maryland 21231 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on set line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ment disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ension Sequentially list conditions Examiner if any, teading to immediate cause. Enter Underlying physician and s the burlal-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed MI ne Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be assisted Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deaus.

To the Funeral Director: After this and any and a second filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 □ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier A/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wn venue. timure

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

5

enson

2. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Xear 20/2 Stella Dorothy Stupavsky /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** APFO IEN KIVER If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month Day 1917 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2√2 F Months Days Hours Min. New York Director 94 096-01-9770 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐Yes 2 →No Funeral Director Maryland Belcamp Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21017 1123 Belcamp Garth 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐Yes 2 ☐ No Completed by If Yes, Give Year or Dates Specify: 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Shoe Manufacturing Stitcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna (nmn) Vrbrovski Stephan (nmn) Scibrane ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1540 Southwest Riverhill Dr., Hermiston, OR. 97838 Shawn A. Kube / Niece 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit, Pages Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State Abingdon, Maryland 09-03-2012 Cokesbury UMC Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) audent Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last for as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Month Day Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **W**No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Plage of Death (Check only one) examiner? examiner? 1 ☐ Yes 2 ☐ No Hospital Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Marmer of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Box 68760,

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

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Medical

(Check only one)

29b. Signature and title of certifier

Pages 1 and 2 should be

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, death. after death Hospital within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28176 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 3: 15 PM Ursula Katharina Snapp SEPTEMBER 3 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death UPPEK. CHESAPEAKE MEDICAL CONTO HARFOLD BELAIR 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Director 67 Germany 1944 337-46-5892 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 Ves 2 No Abingdon Harford Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 21009 2825 Meredith Court 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married δ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public School Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ment. Important: If item 27 is marked any Injury or out. Johann Jakob Rath Elisabeth (nmn) Geborene 19a. Informant's Name/Relationship (Type, Print) 2825 Meredith Court, Abingdon, Maryland 21009 Gary Snapp / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs, LLC 9-5-2012 McComas Funeral Home, P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Examiner NRINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate 2 No 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural work? 1 \(\text{Yes} 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ATTENDING 00067239 2012 DHYSICIAN SOPTEMBER 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) DR MAW NAING

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MEDICAL

HARFORD COUNT

BELAIX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) September 1, Physician/ 2012 6:40 p M Agnes Helen Shaffer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Year) Hours Director 213-38-8072 1 □ M 2 🔀 F Jan. 6, 1941 West Virginia 71 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 USA 100 Green Way Apt. 113 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ا Hygiene. ا **other than** " Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Commisary Worker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ပ (unk) (unk) Virgil Ervin Ferguson Iris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 406 Regina Road, Edgewood, MD 21040 Perry W. Shaffer / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Rose Hill Svcs., LLC 9-5-12 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, lessuce of Weaver 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Muttiorgan System failure disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Intra-abdominal Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Infected apritic graft 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Severe peripheral vascular disease 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No of 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Division within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 3 [only one 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 0 5 2012

D63420

500 upper chesapeake Dr, Bel Air, MD 21014

September 01,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 31 Physician/ 2012 7:10 Scarff \mathbf{P}^{M} May Janice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Cente Towson Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months 219-36-1557 Director 73 1 □ M 2 🕱 F July 30 1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🗓 No Baltimore Phoenix Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21131 U.S.A. 3440 Sweet Air Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes Give Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Inspection Electronics and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bessy May Ball Hyland Augustus injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 7 Zelda Court, White Hall, Maryland 21161 James W. Scarff, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 9/4/2012 Towson, Maryland HilltopServiceCorp 4 Donation 5 Other (Specify) 21. Signature of Fun 111 - vir e Li 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pericardia Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy performed page 2 within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred atural 5 \square Pending 1 Yes 2 No Investigation

or Attending Physician: The law requires that the death certificate be Division of Vital Records, Hospital

2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d Date signed (Month, Day, Year)

State

Registrar

Medical

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only one 29b. Signature and title of certifi

Charles St. Touson

MY

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 1, 2012 George Phillip Schaedel 7:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Sun Valley Assisted Living</u> Taylorsville Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Numbe 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 069-10-0647 1 X M 2 🗆 F 95 Dec. 30, 1916 New Jersey er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Carroll Finksburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2094 Trainer Drive 21048 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event at a proce. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Agent Prudential Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ August Schaedel Louise Stahuber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise S. Retzer / daughter Evergreen Avenue: Arlington Heights, IL 60005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 9/8/2012 4 Donation Other (Specify) Baltimore, MD eral Savice License 21. Signature of Fu 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medica resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of: sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injuly that initiated events Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law
 24 hours after death.
 Funeral Director: After this certificate has better in the funeral director, page 2 settle filled in by the funeral director, page 2 settles prior to completion of cause of death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Spe မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Fres 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 26 Day 08 Month Physician/ JOSEPH ALBERT SHUGH 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Linthicum Heights Anne Arundel Tate Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 215 28 6991 Director 1 🔀 M 2 🗆 F 02 26 1932 Maryland 80 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Pasadena Anne Arundel MD 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 8442 Spring Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced White Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Eastern Airlines Operations Manager other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Norman Herbert Shugh Anna Caroline Karban Department of Health and Important: If item 27 is in any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22737 7366 Laurel Hill LN Rixeyville, VA Stephen Shugh - Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem Pk 8/30/12 Glen Burnie, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral School Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (ances grentra Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician shed for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte d be detached for Month Day Year Pregnant
Unknown Pregnant at time of death 1 Yes 2 9 Unknown 2 No I or Attending Physician: The law requires that the after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24 hours after deatn.

Funeral Director: After this certificate has been signal of the second of the 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No completely filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) Hospice 1 Tyes 2 1 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on within 2 To the 29b. Signature and titl 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

3708 Mountain Rd. Pasadono, MD21122

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

CKristopher
31. Date filed (Month, Day, Year)

deBoria, m.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28181 = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Ellen Terrett Fern September 8:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Senator Bob Hooper Hospice House Harford Forestville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. (Month, Day, Year) Director 215-36-2746 1 🗆 M 2 🔀 F 74 11/22/1937 Washington, DC Usual Residence of Decedent Department of Health and Mental Hygiene. Important: or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21014 400 Harrisson Court, Unit A U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Yes. Give 3 Widowed 4 X Divorced Specify: Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oswald Blankenbaker Ethel Greet J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Harrisson Ct., Unit A, Bel Air, MD 21014 Cynthia Burns / Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 09/05/2012 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Fundamental Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LING Medical (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Dav Year Pregnant at time of death detached 9 Unknown in signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at Natural Accident iniury 5 Pending work? 2 🗆 No Investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year,

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State Registrar			Cei	rtificate	of D	Death			Reg. No.	20	12	28	184
	Di-		1. Decedent's Name (First, Middle, L	ast)							2. Date of De		V	. [3. Time of E)eath
	Physicia Medio		Frank Torcisi								Septem	ber .	1, 2	3 ^r 12	5:00	p_M
in a day	Examin		4a. Facility Name (if not institution, g.	ve street and number)		-	4b. City, To	own, or	Location o	f Death		4c.	County of [Death		
1			8009 McKenstry	Drive			Laure	el				H	oward			
	Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. las	t birthday)	If Under 1 Months	Year Days	If Under I	24 Hrs. Min.	8. Date of Bir (Month, Da	th Vear	g.		ace (State or	Foreign
E	Director		579-34-6406	1 ₹ M 2 □ F	82	Yrs.	IVIORILIIS	Days	Hours	IVIIII.	Sept.1		29 D	Countr _.	7)	
	, MC		Usual Residence of Decedent								Debr.1	2,19	29 0	_		
	yland f sho	tor	10a. State 10b. County			Town or Lo	cation							10	d. Inside City	
	Mar 28a- otifie	Director	MD Howard		Laur	el									1 🗌 Yes	2 X M No
	a or be n		10e. Street and Number				10f. Zip 0	Code				10g. Citiz	zen of Wha	t Count	γ?	
	s 23	Funeral	8009 McKenstry	Drive			2072	23				USA				
	death item ner n		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13.	Was Deceder If Yes, specifi	nt of Hi	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	1	14. Race - A Black, V			
36	filed within 72 hours after death with the Maryland tal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2XXMarrie	1 XXYes 2 □ N If Yes, Give	lo		1 🗆 Yes 2	3.2					Specify:			
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ō	Je 1		20a. Method of Disposition ★★Burial 2 ☐ Cremation 3	Removal from State			osition (Name matory or oth		e) <u>(</u>	Sept	. 7,	20c. Lo	cation - Cit	y or low	n, State	
ij	Pag tmen tant; jury		4 Donation 5 Other (Spe	cify)	St.I	t.Louis Cemetery 2012						012 Clarksvill, MD				
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i		21. Signature of Funeral Service Lice								aldson			ome,	P.A.	
	<u> </u>		John like	M010							Laurel,		20707	-		
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68760	tifica ng p e as t	Me	IF FEMALE:				7.5									
	th ce tend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal (death 3 <u>Լ</u>			у			2	23d. Date o			a cr
Bo	deat the at	/sic	1 Yes 2 No	4 ☐ Pregnant at t 9 ☐ Unknown	time of de	ath 5 L	Other (spe	cify)				i	Month	L	Day Ye	df
P.O. Box	at the	by Physician	Part II. Other significant conditions	contributing to death but	t not result	ting in the I	ınderlying ca	use aiv	en in Part I		220 Did+	abanaa u	o contribut	o to the	cause of dea	ath?
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Ď	ital o															
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attency completely filled in by the funeral director, page 2 should be detached for us	Medical	29a. Certifier 12 Certifying P (Check 2 Medical Exa	nysician: To the best of m miner: On the basis of exa	ny knowled	dge, death	occurred at t	the time	e, date and	place, an	d due to the c	ause(s) an	d manner a	s stated	i. se(s) and man	ner stated.
	the I	Me	only one) 3 Certifying N	urse Practitioner: To the			, death occur	red at th	he time, dat			the cause(s	s) and mann	er as st	ated.	
	Verit		29b. Signature and title of certifier	+			29c. l	License	number			29d. Date	e signed (M	onth, D	1	
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1/	i		30. Name and address of person wh	*		, , , , ,			,							
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	Stat		SEP 0 5 2012	32. Registrar												
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12-06602 Marva Wyche

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 0558 hrs
edical Exami	ter	MARVA WYCHE 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	September	1, 2012 4c. County of Death	
		Sinai Hospital	Baltimore				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Yea Months Day		-1	(MM/DD/YYYY) 9. Bir Foreig	n
Director		230-74-5977 1 M 2XF 63	Yrs.	S Hours Will.	09–11–	-1948 co	untry) VA
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Location				10d. Inside City Limits
	١	MD	BALTIMORE				1 X Yes 2 No
te Maryland or 28a-f show fied at once.	Director	10e. Street and Number	10f. Zip Code	1015	10	g. Citizen of What Cou	ntry?
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hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S 1 Never Married 2 Married Armed Forces?	 13. Was Decedent of His If Yes, specify Cubar 			14. Race - Amer White, etc.	ican Indian, 8lack,
		1 Yes 2 No 3 Y Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No	specify:		Specify: BLA	ск
ours al	ă	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupal during most of working life			16b. Kind of Business/	Industry
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21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner.	Completed by	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, M	aiden Surname)	
215 be file ntal Hy rked o	Be	WILLIE T. ELDER				E. BROWN	
D 21 hould nd Mei is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree				
, MD and 2 sho ealth and em 27 is	ŀ	TONYA LEWIS/DAUGHTER 20a, Method of Disposition 20b. Pi	ace of Disposition (Name of ce		Date Date	MAN, VA 23 20c. Location - City or	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		1 X Burial 2 Cremation 3 Removal from State	ematory or other place)	00.0	00 2012	FREEMAN, V	A 23856
nit. Pa artmer ortani	ł	4 Donation 5 Other Specify: 21: Signature of Funeral Service Licensee	ER FAMILY CEM. 22. Name and Address				NS F.H., INC
Pen Dep Jiji		James a. Mortin	1701 LAUR	ENS ST.,	BALTO.,	MD 21217	
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.			respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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Box 687 he death certific the attending p	Physician	4 Pregnant at time of deal 1 Yes 2 No 9 ✓ Unknown 9 Unknown	th 5 Other (Specify)				
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Division of Vital Records, and a Attending Physician: The law requires after deart. After this certificate has been sited in by the funeral director, page 2 should the fine of the page 2.	၉	1 Yes 2 No 28a. Date of Injury 2	ER/Outpatient 3 DOA 28b. Time of Injury 28c. Inju			Residence 6 Othe	
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	Certification:	4 Homicide determined (Specify) 29a. Certifier A Continue Physicians To the heat of my knowledge					
the Ho nin 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and	e, death occurred at the time, do d/or investigation, in my opinior	ate and place, and on, death occurred at	due to the cause the time, date a	e(s) and manner as state and place, and due to the	ed. le cause(s)
To the within To the compl	Med	and manner stated. 29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mo	
		my he	O.C.	M.E.		September 5, 20	12
10		30. Name and address of person who completed cause of death (Item 2		Aimana MD 040			
,		Ling Li, MD Assistant Medical Examiner 900 V 31. Date filed (Month 1974) 1 32. F.) gistrar's Signatur.		timore, MD 212	223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ Pola Wilder 2012 2:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Adelphi Hill Haven If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2**X**□ F Hours 5-25-1921 Poland Director 109-32-5216 91 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 United States 9503 Thornhill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3X Widowed 4 □ Divorced White Completed Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. I tem 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Nursing Care Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pinina (Unknown) permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any injury or other traumatic. Mendal Alterin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Wilder - Daughter 9502 Thornhill Road, Silver Spring, Maryland 20901 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Elmont New York Beth David Cemetery 9-5-2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Danzansky-Goldberg 22. Name and Address of Facility Edward Sagel al 2 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final FAILURE Onset and Death ACU Physician/ disease or condition Medical resulting in death) Examiner ARRHYTHMIA ARDIAC Esquendiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ANEMI burial-trar Due to (or as a consequence of) resulting in death) Last DISEASE attending physician Physician/Medical ORONARY certificate be 68760 as IF FFMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown P 5 Other (specify) Month Day Year Pregnant at time of death the detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No the Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be M Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D0052855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7207 HANOYER PARKUAY GREENBELTM-DWD CHANDRA KORAPATI 31. Date filed (Month, Day, Year) **SEP 0 5 2012** 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:35 PM Charlie Lee Wilson September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months (Month, Day, Year) Dec 25, 1943 Hours Country) Virginia 68 Director 225-56-7579 1 M 2 □ F permit. Pege 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is merked other than "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1914 Barry Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retirement Community Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Lee Wilson Ollie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Bryant / Grand-daughter 1914 Barry Road Dundalk, MD 21222 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 04 Sep 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2012 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) schemic terrs Medical Thue to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): ettending physicien end for use es the burlei-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the er d be deteched fo 1 Yes 2 L g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š end stage renel 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physicien: The lew hes autopsy page performed? certificete 1 Yes funerel director, 25. Was case referred to medical 8 26. Place of Death (Check only one) 2 DX)No Other: 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death, the Funerel Director: After in appletely filled in by the funer 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier Scotember 2 2012

State Registrar DHMH 17 Rev 06-201 30. Name and address of

31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of For	neral Service Lice		110000) Ř	2. Name and A	ddress nera	of Facility an	d Cr	emation	n Serv	ice			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Woodard Rosalie Month Day 201^Y2 31 6:019M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 218-38-7861 Days Months Hours March 24, 1939 Country) **Director** 1 ☐ M 2 ☐**X**F 73 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2095 Rockrose Avenue 21211 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give ted 3 Widowed 4 Divorced White Specify: Year or Dates Complet Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Allen Barber Mild Jeanette Lescure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brett Woodard 102 Central Avenue North Babylon NY 11703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12 North Babylon NY Date 1 M Burial 2 Cremation 3 Removal from State North cranto y 1th filactemetery 9/8/ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. altine Essex 21221 Connelly Funeral Home of 23a. Part 1. Enter the disease, or complications that caused the oeath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (N as a constituence of): disease or condition resulting in death) Medical Examiner 06 8 hu Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence on Damentre the burial-tran that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exectivithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician at completely filled in by the funeral director, page 2 should be detached for use as the burial-to Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. BITAWST Shite 308 Baltimore MD 21201 HAS HIMI MD 31. Date filed (Month, Day, Year) -Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Month ()9 Physician/ 02 2012 4:15 AM Edna Odessa Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Oxon Hill 747 Audrey Lane 7. Age (In yrs. last birthdav) If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth **Funeral** Months Davs Hours Min 1 □ M 💥 F (MO672811920 North Carolina 92 Director 218-24-0273 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland must be notified at Director Yes 2 No Oxon Hill MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 50 items 23a Funeral USA 20745 747 Audrey Lane death v Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes X No Specify: If Yes, Give Year or Dates "natural" 3X Widowed 4 □ Divorced Black Completed Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7.
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Important if item 27 is marked other than any injury or other traumation. life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Annie Stevens William Whiteside 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 747 Audrey Lane, Oxon Hill, MD 20745 Carrie Louise Yates / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 9/5/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, Baltimore, PO Box 1413 MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ years ementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical phys the b attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Day 5 Other (specify) Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has Yes 2 XN 1 Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 1 TYes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ this 28a. Date of injury (Month, Day, Year) hin 24 hours after death.

the Funeral Director: After thi

upleted filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 only one 29b. Signature at title of ceAfie 29c. License number 29d. Date signed (Month, Day, Year, 2012 AC00093

DHMH 17 Rev 7/2009

State Registrar 180 Large

MD 20774

12-06565 Bernice Watson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bernice Watson	1- For State		ent of Health and M ate of Death		eg. No. 201	2 2818
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Bernice		Watson	2. Date of Dea Month August 31	ith	3. Time of Death 0925 hrs
	4a. Facility Name (if not institution, give stree 3123 Artaban Place	t and number)	4b. City, Town, or Local Baltimore		4c. County of Deat	h
Funeral Director	5. Social Security Number 6. Sex 218-42-1403 1 M 2	7. Age (In yrs, last birt	**	lours Min	rth(MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn buntry) MD
and show any acc.	Usual Residence of Decedent 10a. State 10b. County MD NA	10c. City, Town	or Location .timore			10d. Inside City Limits 1 X Yes 2 No
the Maryland or 28a-f sh tiffed at one Director	10e. Street and Number		10f. Zip Code 21216	1	0g. Citizen of What Cou	intry?
death with or items 23. must be no Funeral		Vas Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	kican, Puerto Rican, etc.)	White, etc.	rican Indian, Black,
5-0036 ed within 72 hours after 1/9giene. other than "natural", the Medical Examiner Completed by I	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	nest grade completed) 16a. I	Decedent's Usual Occupation (G during most of working life, DO I Housekeeper	NOT use retired)	16b. Kind of Business.	Facilitie:
21215-0036 Juld be filed within 7 Mental Hygiene. In merce of the Medical free event, the Medical free free event, the Medical free free free free free free free fre	17. Father's Name (First, Middle, Last) John Watson 19a. Informant's Name/Relationship (Type, P	rint) 19t		other's Name (First, Middle, ie William Number or Rural Route Nur	s	e. Zip Code)
ore, MD 21 ss 1 and 2 should of Health and Me If item 27 is ma her traumatic ev	Kevin Watson-Son 20a Method of Disposition	20b. Place of	3123 Artaban of Disposition (Name of cemeter	Place, Bal		d 21216
	1 Repaired 2 Cremation 3 Re 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Illoval Ilolli State	ory or other place) Sus Memorial March Address of F	9/10/2012	Arbutus,	Mđ
Balt Bemit. Depart Importing Injury	23a. Part I. Enter the disease, or complication		4300 Wabash	n Ave, Balt		Approximate Interval
Medical Examiner	or condition resulting in death) Due to		erosclerotic Ca	rdiovascular	Disease	Between Onset and Death
ed nsit Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause C.	(or as a consequence of):				
be executed cian and unial - transit edical Ex	d	ended 23a,pt.II,2	27,per me,g931	9-10-12 sm		
tox 68760 eath certificate attending phys for use as the brandard.	OOL Man decade at a segment in the	Live birth Pregnant at time of death Unknown		ctopic pregnancy	23d. Date of deliver Month	y Day Year
rds, P.O. B requires that the d been signed by the hould be detached letted by Phy	Part II. Other significant conditions contr Diabetes	buting to death but not resulting	g in the underlying cause given	1Ye		bably 4 Unknown
Division of Vital Records, P.O. pital or Attendiog Physiciae: The law requires that th ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deated. Certification: To Be Completed by P				1 ✔ Yes		utopsy findings available completion of cause of
FVital Rec Physiciao: The ar this certificate ral director, page To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No	:	utpatient 3 DOA Othe		Residence 6 🗸 Othe	er: Scene
ion of tending Pleath. ctor: After the funeral y the funeral:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Time of Injury 28c. Injury at 1 Yes	2 No	how injury occurred	
Division or vite Hospital or Attendiog within 24 hours after death. To the Fuoeral Director: Afte completely filled in by the fune Hodical Certification:	Suicide Could not be determined	Specify)	arm, street, factory, office buildir	or Town,	State)	ural Route Number, City
To the Hos within 24 h To the Fuc completely	one) 2 Medical Examiner: On the	o the best of my knowledge, de ne basis of examination and/or i nanner stated.	ath occurred at the time, date ar investigation, in my opinion, dea	th occurred at the time, date	and place, and due to t	he cause(s)
	29b. Signature and title of certifier	4	29c. License nur O.C.M.E		29d. Date signed (Mo	
	30. Name and address of person who comple Jack Titus MD. Deputy Chie		00 W. Baltimore Street,	Baltimore, MD 21223		
State Registrar		32/Registrar's Signature	parel			

12-06440 James Withrow Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lames Withrow	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012	2819									
Physician/ Medical Examiner		ime of Death 800 hrs									
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Center 4c. County of Death Glen Burnie Anne Arundel										
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplact Foreign Country) Months Days Hours Min. 12 09 1976 Country)										
any	Usual Residence of Decedent	Inside City Limits									
È.,	MD Anne Arundel Chestnut Hill Cove	Yes 2 No									
r 28a-f	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?										
auth with the Maryland items 23a or 28a-f sho sat be notified at once ineral Director	1136 Veranda Ct. 21226 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American In	ndian, Black,									
F. F.	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Ma	ite									
hours after and the state of th	of Dates:										
11215-0036 de filed within 72 hours fental Hygiene. narked other than "naturevent, the Medical Exam De Be Completed to	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Tatoo Artist Fine Arts										
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than a market ceent, the Medica aumatic event, the Medica To Be Compli											
212 bould be and Ments is mark ritic even	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	Code 21226									
and 2 shou ealth and 1 stem 27 is remartic	Anna Withrow - Wife 1136 Veranda Ct Chestnut Hill Cove, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town,	MD									
TOFE Pages 1 ent of H nt: If it	1 Burial 2 Tocremation 3 Removal from State Removal from State Bayview Crematory 9/1/2012 Baltimore,	MD									
Baltimore, MI permit. Pages I and 2.8 Department of Health a Important: If Item 27 injury or other traum	21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Hol	me, PA									
Physician		21122 proximate Interval tween Onset and									
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death									
	Sequentially list conditions, b.										
ted Insit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Cliseas or highry that imitated c.										
uted nd ransit	vents resulting in death) Last Due to (or as a consequence of): d.										
50, te be executed ysician and burial - transit	■ MENDED 23a,27,28a-f,per me,g931 9-10-12 sm										
eath certificate eath certificate at the certificate for use as the ferus for use for u	F FEMALE: 23c. If yes, outcome of pregnancy 1	Year									
). Box 68760, the death certificate be the death certificate be by the attending physicicle for use as the burn Physician/Med	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown										
P.O. Es that the congress that the congress by the detached by the legal by the legal by the legal by Physical by											
w requires been sign should be oleted be	24a. Was an 24b. Were autopsy	findings available									
of Vital Records, is Physician: The law requires the continue has been signeral director, page 2 should be no To Be Completed	autopsy prior to comple performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	etion of cause of									
ital Recicion: The certificate rector, page	25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other Description 2 PRovidence of Death (Check only one)										
ing Physical ding Physical din	27. Manner of Death 28b. Time of Injury (Month. Day.Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred										
Division tal or Attendi rs after death. al Director: ded in by the fu ertification	Accident Natural 2 Accident 5 Pending Investigation	ute Number City									
Division o ospital or Attending hours after death. Innertal Director: After y filled in by the function: Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Jail/Penal 28f. Location (Street and Number or Rural Roor Town, State) 534 House of Jessup, MD.	Correction									
the Ho nin 24 H the Fu upletely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner stated.	se(s)									
To with To com	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of Certifier)	ay, Year)									
	30. Name and address of person who completed cause of death (Item 23a)										
0	Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
State Registrar											

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CO RANDALLSTOWN NORTHWEST HOSPICE If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) Director 240-30-8696 1 🗆 M 2 🗓 F 95 APR. 6 1917 NORTH CAROLINA Usual Residence of Deceden permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director XX Yes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21215 U.S.A. 2552 DRUID PARK DR. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 NNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC LAUNDRY PRESSER 3rd grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BELLE LEARY WILL LEARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2552 Druid Park Dr., Baltimore, Md., 21215 Edith W. Schenck/Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09/02/2012 Kings Mountain, N.C. 4 Donation 5 Other (Specify) Olive Cemetery Mt. 21. Signature of Funeral Service Li While Tand dess of Facility COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE., BALTIMORE, MD., 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final cardiothrombotic Event Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atheroscherotic Lardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on Hospital or Attending Physicien: The lew requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 24 hours after death.

9 Funeral Director: After this certificate has been signed by the a letely filled in by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury □ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical To the Hospl within 24 hou To the Funer completely fil 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRaj aprine MD D005 7465 8/24/12 184 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21061 6934 BIVD Burnie Aviation GHEN 31. Date filed (Month, Day, Year) SEP 0 5 2012 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 18 2012 Ernest M. Atwell August Medical 11:55AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 8 Date of Birth Months Days Hours Min (Month, Day, Year) Director 213-42-2951 1 🔀 M 2 🗆 F 66 Yrs. 09/15/1945 Pennsylvania ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Havre de Grace 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1844 Pulaski Highway, Lot 14 21078 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 X Married Black, White, etc. δ 1 Yes 2 No If Yes, Give 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1964-67 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other to any injury or other traumatic event, the once. Government Civil Service æ Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl F. Atwell Agnes Bedwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Atwell (wife) 1844 Pulaski Hwy,Lot 14, Havre de Grace,MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem.Garden 8/24/2012 Aberdeen, MD 21. Signatule of Fundati Servic License 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St., Havre de Grace, MD 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fatture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Lause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires to hours after death, Funeral Director: After this certificate has been sign 24 hours after death, be funeral **Director**. After this certificate has been signed in by the funeral director, page 2 should the fulled in by the funeral director, page 2 should the funeral director. 1 🗆 Yes 2 🗆 No 3 🗀 Probably 4 💓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 🗌 Yes] No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ဂ္ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natura. 2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 only one) 29b. Signature and tite o son who completed cause of death (Item 23a) (Type, Print 30. Name and ad State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Amended #26 perphysician 8/20/2012/cchd/ba
Registrar Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:10 a_M Madeline Arrington-Sharp 2012 Medical Aua 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George Bowie Health Center-Emergency Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Manth, Day)
Sept 17 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 Tr North Carolina 246-30-7325 88 **Director** Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Bowie Prince George 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20715 7910 Orchard Parkway USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Own HOme Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Dempsey Cassie Arrington 19a. Informant's Name/Relationship (Type, Print) 195 Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Code 7910 Orchard Parkway Bowie, MD 20715 Sharon Sharp-Harrison permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery 8/20/2012 NOrfolk, 4 ☐ Donation 5 ☐ Other (Specify) Signed re of Funeral Service Licensee 22. Name and Address of Facility Metropolitan FuneralService 120 West Berkley Ave. Norfolk, VA 23523 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fulure nameno Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of): Examine Due to been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) be detached for in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2/ Other: No 1 Yes 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident work? 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital of the Hours a To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9-15-12 010123993 828 Healthy Way Suite 220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 31. Date filed (A

Virginia Beach, VA 23462

 (λ)

32. Registrar's Signature

			For State Registrar	Plea	se Type or Amend State o Amend	Print in #30 pe f Maryla	Black ly Pep; Cei	artme	bje in Pataof Staof Late of Late	12 d lealth per Death	ure A and N me,g	Vental Hy	es Ar gjen Reg. N	e Legi	ible.	28	194
	Physicia	ın/	1. Decedent's Nam	e (First, Middle	, Last)				_			2. Date of D Month	eath D	ay	Year	3. Time of 12:15	Death P M
and and	Medic Examir				n Armstrong give street and num	ber)		4b. Ci	ty, Town, or	Location	of Death	Aug 14		c. County	of Death	L	
	F		Prin 5. Social Security N		e General Ho		. last birthday)		heverly	y If Under	24 Hrs.	8. Date of B	irth	Princ	e Geo:	rge's	r Foreian
	Funeral Director		578 60 258 Usual Residence	2 of Decedent	1 □ M 2 🗓 F	66	Yrs.	Month		Hours	Min.	(Month, D Aug 4,	lay, Year)		Was	hington	DC
	iryland a-f sho ied at	ctor	10a. State	10b. County	0	10c. (City, Town or Lo								1	0d. Inside Cit 1 🗌 Yes	
	the Ma or 28s	Funeral Director	Maryland 10e. Street and Nur		George				wie Zip Code				10g. C	Citizen of W	/hat Coun		- M
	th with ms 23; must J	inera		emory La		Lant Constant	lo lao	Was Day		0712	1-1-0 (0-	- if . Vee or No		United			
980	I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Itygiene. If Health and Mental Itygiene. And Tis marked other than "natural", or items 23a or 28a-f show quher traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1		ied 12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 XXNo		f Yes, sp	ecify Cuba	ın, Mexica	n, Puerto	ecify Yes or No Rican, etc.))-		- America k, White, e Whi		
21215-0036	72 hou n "nat u ledical	nplet		cify only highe	nt's Education st grade completed)			kind of v	sual Occup vork done c use retired)		st of work	ing	16b.	Kind of Bu	siness/Inc	dustry	
212	within giene. er thar t, the N	Cor	Elementary/Seco	ondary (0-12) 12	College (1-	·4 or 5+)	Bin		ise retired)		_			Printe	er Sho	p	_
Maryland	ild be nied Mental Hy narked oth latic event	To Be	17. Father's Name (First, Middle, L ndery	ast)					18. Moth		e (First, Middle inter Sh		n Surname,)		
Mar	2 shou th and 27 is m traum		19a. Informant's Na		nip <i>(Type, Print)</i> rong (Husbar	nd)						al Route Numb , MD 207		or Town, St	ate, Zip C	Code)	
	of Health of Health of Item 27 i		20a. Method of Disp	oosition	3 Removal from	20b	. Place of Dispo	sition (N	lame of	1		Date		Location -	City or To	wn, State	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.	- 5	4 Dopation	5 Other (S		- 1	Lee Crem	atory		Ĺ		8, 2012		Linton		VI J A1	أم تسائمه
Ba	Depar Impor any ir	17	21. Signal leg f Flu	WY	Mary							Funeral 20735	Home,	, Inc () 	nd Alex	aluria
æ. P	h,sician/		shock, or heal Immediate Qause (disease or condition	complications that c nly one cause on ea	aused the de th line.	ath. Do not entended Multipl	er the m	ode of dying	g, such as	cardiac	or respiratory a	arrest,	lan	1	Approximate Interval Betwoen Onset and I	ween	
200	Medical Examiner		resulting in death) Due to (or as a consequence of):														
	# # # # # # # # # # # # # # # # # # #	niner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate rlying	b. Due to (or as an insequence of):												
	att certificate be executed attending physician and for use as the burial-transit	al Examiner	Cause (Disease of that initiated events resulting in death) I	injury S	c. Due to (or as a conse	equence of):			1	OF DIFFIC	ATION APPROV	ED BY M	EDICAL EXP	MINER		
68760	g physi	Nedic			d						CERTIN						
Box 68	To the hospital or steaming tripstoan, the law requires that the detail certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 13 u 1 ☐ Yes 2.0 9 ☐ Unknown	onths?		Birth 2 🗀 Fo	etal death 3		ic pregnanc (specify)	Ey .				23d. Dat Mor	e of delive	*	√ear
P.O.	gned by be detac	by Ph	Part II. Other signif	icant condition	ons contributing to de	eath but not r	esulting in the u	ınderlyir	g cause giv	en in Part	t.			~/		ne cause of d	
of Vital Records,	been si should	Completed										1 L 24a, Wa		$\overline{/}$		oably 4 🗌 I	
3ec }	nis certificate has t il director, page 2 s	omo										aut	opsy formed?	F B		mpletion of c	
Ta]	certifica rector,	Be	25. Was case referre	_	Hospital:				Othe	or.		k only one)					
of V	er this	te: To	1 Yes 2 2 27. Manner of Death	1	28a. Date		ER/Outpatier 28b. Time of injury		28c. Injury	4 ∐ N ⁄at	lursing H	ome 5 Res 28d. Describe	how inju	ury occurre	ed		
ion	death. tor: Aft	Certificate:	1 X Natural 2 X Accident 3 Suicide	5 ☐ Pendir Investi 6 ☐ Could	gation 8-13-	2012	7:00	P M		Yes 2	No	subjec					
Division	urs after or an area of a series of a seri	al Cer	4 Homicide	determ	buildir	ng, etc. (Spec	home, farm, str					Rowie,	MD .	te)1262	З Мет	nory Li	er, 1.
-	n 24 ho	Medical		Medical E	Physician: To the be xaminer: On the bas Nurse Practitioner:	is of examinat	ion and/or inves	tigation,	in my opinio	on, death o	occurred a	t the time, date	and plac	ce, and due	to the car	use(s) and ma	nner stated.
- i	with:		29b. Signature and	title of certifier	-	_		2	9c. License		2,	6	29d. D	ate signed	(Month)	Day, Year)	
	0/0				who completed caus				1		3/0		<	7/19	1//		
	By		Demetrio	s Cate	venis, 300	1 Hos	pital D		, Che	rver	ly M	20785	<u> </u>				
1	Sta Registra		31. Date filed (Mont	AUG 2 (2012	egistrar's Sigr	nature	alle	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	arylan					d Mental Hy	giene			
			1 - State Registrar			Cer	tificate	of De	eath		Reg. No. 2	012	28	195
	Physicia	in/	Decedent's Name (First, Middle, Last)	, ,	4	_	, n			2. Date of De Month	ath Day	Year	3. Time o	
-	Medic		4a. Facility Name (if not institution, give str		dan:	5	or. Lab Ciba Ta		ocation of De	Angus		2012	3:43	А м
song le	Examir	ier	8910 LOUGHRAM RD	oot and nambery			, ,		NGTON	alli		inty of Death NCE GEO	DCEIC	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. la	st birthday)	If Under 1	Year	If Under 24 H		th	9. Birthp	lace (State o	
	Director			M 2 □ F	74	Yrs.	Months	Days	Hours M	in. (Month, Da	. ,	Coun	DC	
	nd how	=	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation			11/29/	1937	1	Od. Inside C	itv Limits
	faryla 3a-f s tified	ecto	MD PRINCE GE	ORGĖ'S	FT.	WASHI	NGTON							s 2 🗆 No
	the f	Ē	10e. Street and Number				10f. Zip (10g. Citizen	of What Coun	try?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show er than Medical Examiner must be notified at	Funeral Director	8910 LOUGHRAM RD				20	744			UNITEI	STATE	S	
	death r item iner n			Was Decedent Ev Armed Forces?			Vas Deceder Yes, specif	nt of Hisp y Cuban,	anic Origin? Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, e		
36	al", or	d b	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 1		000	☐ Yes 2	X No	Specify:			cify: BLAC		
9-0	hours natura lical E	lete	15. Decedent's Educ	Year or Dates 19 cation	1-051	16a. Deced	ent's Usual					f Business/Inc		
21215-0036	in 72 e. "nan ",	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5-	+)	(Give F life, D(kind of work O NOT use n	done dur etired)	ring most of w	vorking			,	
21	e filed within ntal Hygiene. ed other thal event, the N	Be C	12th			CORREC	CTIONA	L OF	FICER		GOVE	RNMENT		
and	be filed ental Hyg ked oth ic event	To B	17. Father's Name (First, Middle, Last) THEODORE ADAMS					- 1		lame (First, Middle,	Maiden Surn	ame)		
Z	should be file and Mental is marked of raumatic eve		19a. Informant's Name/Relationship (Type	Print)	_	10h Mailin				Y BOWLES	Other and Taxon	- 04-4- 7:- 0	la adal	
M	- B 12 B		RUTH C. ADAMS/ WIF	,		100				Rural Route Numbe WASHING				
re,			20a. Method of Disposition		20b. PI	one of Dieno	cition (Namo	of		Date		on - City or To		
imo	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation, 5 ☐ Other (Specify)	emoval from State	MARS	emetery, crem LAND CEM	VETERA ETERY	NS	087	23/2012	CHELT	ENHAM,	MD	
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signa up se uneral Service Licknsee	// .						POPE FUNE				
-	<u> </u>		Janny L	1 Immz						E, FORES		, MD 20	0747	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.				of dying,	such as cardi	ac or respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
, De.	Physician/ Medical		disease or condition resulting in death)	PARKINS			ASE						Onset and i	Jean
-	Examiner			Due to (or as a	conseque	ence oi):								
1	1000	iner	Sequentially list conditions, b. in any, leading to immediate cause. Enter Underlying	Due to (or as a	#onsequ	ande Oi):						-		
	outed nd transit	Examiner	Cause (Disease or injury that initiated events c.											
	ate be executed bhysician and the burial-transit	al E	resulting in death) Last	Due to (or as a	conseque	ence of):								
760	physic physic the t	edical	d.											
189	Sertific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome o	of <u>pr</u> egnan	ncy					234	Date of delive	n/	
Box 687	eath o	icia	in the past 12 months? 1 Yes 2 No	4 Pregnant at	Fetal time of de	death 3 Leath 5 L	Ectopic pre Other (spec	egnancy c <i>ify)</i>					•	Year
Э. Е	hat the death certifica ed by the attending pl detached for use as t	Physician/Me	g 🗌 Unknown	g 🗌 Unknown										
, P.O.	v requires that been signed t should be det	by	Part II. Other significant conditions conti	ributing to death bu	t not resu	ılting in the uı	nderlying ca	use given	in Part I.			ontribute to th	N/	
rds	equire een si nould	Completed								_ 1 🗆	Yes 2 □ N	o 3 🗌 Prob	ably 4	Unknown
000	e law r has b ge 2 sl	mple								24a. Was	osy	 b. Were autop prior to cor death? 	sy findings a npletion of c	available ause of
ž	n; The ficate or, pag		25. Was case referred to medical			_				perfo 1 ☐ Yes	2 X No	1 Yes	2 🗆 No	
/ita	sicial s certi	To Be	evaminer?	spital:	o 🗆 r	ER/Outpatien	- 2 DOA	Othor		heck only one)				
Division of Vital Records,	g Phy er this neral o		27. Manner of Death	28a. Date of injury	/ :	28b. Time of		c. Injury at		Home 5 Resid				
on	endin sath. or: Aft she fur	ficat	1 Natural 5 Pending 2 Accident Investigation	(IVIOTILII, Day,	rear)	injury	М	work?	s 2 No					
ViSi	or Att fter d irect in by 1	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		ne, farm, stre	et, factory, o	office		28f. Location (S		mber or Rural	Route Numb	er,
Ō	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		29a. Certifier 1 Certifying Physici	ana Ta shar basat as a				h = 41			(2)			
	e Hos 124 he e Fun letely	Medical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner 3 Certifying Nurse F	r: On the basis of exa	amination	and/or investi	gation, in my	opinion,	death occurre	d at the time, date a	nd place, and	due to the cau	se(s) and ma	nner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Tuotidoner: 10 tile	best of m	y Knowledge,		_icense nu				ned (Month, E		
				3 ANI	7- B	C	A	460	0093	7	Augus	c+ 15	20	12
	36 T ₆ %		30. Name and address of person who com	pleted cause of dea	ath (Item :	23a) (Type, P	rint)				'			
			MELONIC REYNOLDS, 31. Date filed (Month, Day, Yer)					DR.	, STE	180, LAR	GO, MD	20774		
	Stat Registra		AUG I (2012	32. Registrar	s signatu	ben	col							
				4	-	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30^{ay} Physician/ Month 2012 Year Margaret Elizabeth Anderson 4:59 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6607 Oak Orchard Court Prince George's Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Days Director 577-14-3055 92 1 🗆 M 2 🗓 F 9/27/1919 Washington, DC 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No DC None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4521 Illinois Avenue NW 20011 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces? 0. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Brown Virginia Morse injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Yvonne Makell/Daughter 6607 Oak Orchard Court Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Resurrection Cemetery 08/07/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final NO SCIEND) I Physician/ C disease or condition Medical resulting in death) Examiner ASCHIAN INSUFFERM EREBRAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that the death certificate be executed burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Pregnant at time of death Day Year the 9 I Inknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 3 N 1 Yes 2 X No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🛚 No Other: 4 Nursing Home 5 Residence 6 XDaysbter's Home 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Accident 5 Pending 1 🗆 Yes 2 🗌 No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the bisis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. phelmorth lyne for ten Certifying Nurse Practitioner To the death continued at the time, date and place, and due to the 29b. Signatur 29d. Date signed (Month, Day, Year) 2 em 23a) (Type, 20603 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Dilali Adda		1-For State Certificate of Death	ivientai Hygier	Reg.	No	
Physicia	ın/	Decedent's Name (First, Middle,Last)		e of Death	201	2 Time of Delin 9
Medical Examir	ner			oth Dust 1, 20		2023 hrs
and a		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital 4b. City, Town, or Loc Takoma Park			4c. County of Death Montgomery	
Funeral Director				ate of Birth()/09/1	MM/DD/YYYY) 9. Bir .987 Foreig	thplace (State or gn untricameroon Arrica
Any	-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and show	5	MD Prince Georges Hyattsville				1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code		ľ	Citizen of What Cou	•
th the 23a or		3202 Toledo Place Apt. 203 20782			meroon, A	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must he notified at once.	Funeral	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispan If Yes, specify Cuban, Me	lexican, Puerto Rican,		14. Race - Amer White, etc.	ican Indian, Black,
s after ral",	2	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No sa		- 12		ack
2 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation during most of working life. DO		ne [1	6b. Kind of Business/	Industry
036 thin 7 than edical	힏	2 years Nurse			Private	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) 18.N	Mother's Name (First, I	Middle, Mai	den Surname)	
121 d be fi lental] arked	B B	Wilson Adua 19a, Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street an	ridget Anw	<u>ei Te</u>	bo	
Shoul shoul and M	٩	19a. Informant's Name/Relationship (Type, Print) Bridget Adua / Mother 3202 Toledo P1				
and 2 and 2 fealth frem 2 fraun	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter			Oc. Location - City or	
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		1 Burial 2 Cremation 3 Removal from State crematory or other place) A Proposition 5 Other Specific	0010510	C	ameroon	
altin nit. P sartme sortan	ŀ	4 Donation 5 Other Specify: Gathoric Genetal y 21 Synature of Funeral Service Licensee 22. Name and Address of Funeral Service Licensee 25. Name and Address of Funeral Service Licensee 26. Name and Address of Funeral Service Licensee 27. Name and Address of Funeral Service Licensee 28. Name and Address of Funeral Service Licensee 29. Name and Address of Funeral Service 29. Name and Address of Funeral	Facility Johnson	0121 1 & Je	nkins Fun	eral Home
P. P	-	Cruletta Hygen 716 Kennedy	ST NW WDC	20011		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc failure. List only one cause on each line.	ch as cardiac or respira	atory arrest	, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Cardiomegaly with Asymmetric Biventricular Hypericular Due to (or as a consequence of):	rtrophy and Fibro	sis		Death
		Sequentially list conditions, b				
	iner	if any, leading to immediate Due to (or as a consequence of):				
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	a E	d				
be ex sician sician	Medical	UNPENDED AMENDED				1
876 ifficate ig phy is the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of delivery Month	y Day Year
x 60 th cert ttendir r use a	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)				,
Bo he dea	y y	1 Yes 2 No 9 Unknown 9 Unknown	- in Post I	a Did toba	and the same and the same and	the server of death?
, P.O.	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given		Yes	cco use contribute to	ably 4 V Unknown
ds, Fequires	ted		VL_	a. Was an		topsy findings available
COF	Completed			autopsy	prior to death?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical 26.Place of E	Death (Check only one	Yes 2	No 1 Y	es 2 No
Vital hysician this cert	ă۱	examiner? Hospital: Other			sidence 6 Other	
of \\ ing Phy After th	읽	1 ✓ Yes 2 No 1 inpatient 2 ✓ ENOutpatient 3 DIA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at			v injury occurred	
lon tendin eath.	흹	1 V Natural 5 Pending 2 Accident Investigation	2 No			
Vision or At Or At Direct of In by	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office buildi		cation (Stre		ral Route Number, City
Spital Di filled	Certification:	4 Homicide determined (Specify) 29a. Certifier 4 Contact of Physics Contact of Contact				
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil - transi	Medical	Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead and manner stated.				1
F % F 8	ğ	29b. Signature and title of certifier 29c. License nu		2	9d. Date signed (Mor	nth, Day,Year)
		Carde Hallaa O.C.M.E	Ε.	P	August 2, 2012	
35M	- 1	30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD. Assistant Medical Evaminar, 200 W. Paltimore Street	Rollimore MD 3	1222		
	100	Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, Daitimore, IVID 2	. 1223	-	
Sta Registr	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28198 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edward 2012 Dona1d Bryant, Jr. August 4:56 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7535 Cameron Ridge Road Hughesville Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Director 578-88-4155 1 X M 2 🗆 F 53 Alabama 07/07/1959 Usual Residence of Decedent show 10a. State 10c. City, Town or Location Director notified 28a-f 1 Tes 2 X No Maryland Charles **Hughesville** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be 1 Funeral 7535 Cameron Ridge Road 20637 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 X Married o by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Substation Technician Electric Power Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Donald Edward Bryant, Sr. Jeanette Crossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Clairisa Bryant/Wife 7535 Cameron Ridge Rd., Hughesville, MD 20637 other 1 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H important: If ite any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-EcholsCrem, 08/18/2012 Charlotte Hall, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Secure tially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of attending physician for use as the buria Physician/Medical 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? Month Year Dav 1 Yes 2 No g 🗌 Unknown P.O. ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 🗌 Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 Yes 2 No 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of artifi 29d. Date signed (Month, Day, Year) 2012

State Registrar

DHMH 17 Rev 06-2011

37767 Market Drive, Charlotte Hall, MD 20622

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manoj Panwala, M.D.,

AUG 2 1 2012

31. Date filed (Mon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ Month 7:05 P_{M} Joseph Beatty III Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Montgomery Potomac Manor Care Potomac 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Days Hours 579-38-9685 Director 1 🗶 M 2 🗆 F Washington, DC 06/19/1924 88 show ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Chevy Chase 1X Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 20815 8100 Connecticut Avenue United States ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' or Black, White, etc. 1 \square Never Married 2 \square Married þ X Yes 2 No World within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify:White 3 X Widowed 4 Divorced Completed Year or Dates. War II 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Kraft Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygier is marked other t Corporation Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Joseph Beatty Jr. Helen Simpson other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or attention 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 West Irving Street Chevy Chase, MD 20815 Patricia Abell / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Potomac, MD 4 ☐ Donation 5 ☐ Other (Specify) Gabriel Cemetery 8/16/12 22. Name and Address of Facility Joseph Gawler's Sons LLC. of Funeral Service Licensee M000635130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Ischemic Cardiomyopathy Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). Tages of the same The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year the g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Atrial Fibrillation 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate Yes 2 X No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🛚 No Other ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ D55258 August 14, 2012 10 of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

AUG 16 2012

Gary Willes MD 7758 Wisconsin Avenue Suite 211 Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene Physic Med

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	-	For State Of Wai yiand I	Cer	tificate of	Death		Reg. No.	112	28200
Physicia		Decedent's Name (First, Middle, Last) CORNELLUS LEVIN BUTLER				2. Date of Dea		2 ^{Year}	3. Time of Death 10:36 A M
Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, c				y of Death	1 - 0 - 0 - 0
Funeral		108 GENTRY COURT 5. Social Security Number 6. Sex 7. Age (In yrs. last to the property)	birthday)	If Under 1 Year Months Days	If Under 24 Hours M		h	9. Birth	place (State or Foreign
Director ≽		579-86-8953 Usual Residence of Decedent	Yrs.			JAN 6,	1963		IINGTON, DC
Maryland 28a-f show otified at	Director	10a. State 10b. County 10c. City, To CHARLES BR	own or Loc YANS						10d. Inside City Limits 1 XYes 2 □ No
vith the M 23a or 28 st be not		10e. Street and Number		10f. Zip Code 20616			10g. Citizen of	What Cour	
leath wi	Funeral	10. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V		Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Ra	ce - Americ	can Indian,
within 72 hours after death with the Maryland agiene. giene. than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	ed by	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 N No If Yes, Give Year or Dates.	1	☐ Yes 2 X No		orto rusan, etc.,		ack, White, y: BLA (
72 hour n "natu Aedical	Completed	(Specify only highest grade completed)	(Give I	lent's Usual Occu kind of work done O NOT use retired	during most of v	vorking	16b. Kind of B	Business/In	dustry
d within 7: ygiene. her than nt, the Me	a)	Elementary/Secondary (0-12) College (1-4 or 5+) 12TH		SERVICE	E MANAGE			DD SEI	RVICE
should be filed within and Mental Hygiene. is marked other tha aumatic event, the N	To B	17. Father's Name (First, Middle, Last) JAMES BUTLER				Name (First, Middle, ON BUTLER	Maiden Surnan	ne)	
shoor h and 7 is n traun						Rural Route Number			
		20a. Method of Disposition 20b. Place 20b. Place 20c. Method of Disposition	e of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location	- City or To	own, State
nit. Page bartment c fortant: If injury or e.		4 Donation 5 Other (Specify)				IST 25,2012			
permit Depar Impor any in		PLYDIA C. THORNTON JOHNSON/MO0583				HOME, P ROAD, INI		AD, M	
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	V W	1 A ST	facul		+S12,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) a. Due to (or as a consequence)	ce of):	I MO	145	TUC			
- 4	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):	-5110		<u> </u>			
executed n and ial-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence resulting in death) Last Due to (or as a consequence consequence)	ce of):						
ficate be executed g physician and as the burial-transit	edical	d							
h certific tending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de	eath 3 🗀		ncy			ate of deliv	•
the deat by the at ached fo	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	th 5 L	Other (specify) _			IVI	onth	Day Year
res that the death certi signed by the attendin d be detached for use	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	inderlying cause g	iven in Part I.	23e. Did to	1/		he cause of death?
av require as been si 2 should	Completed					24a. Was a		. Were auto	psy findings available impletion of cause of
n: The la ficate ha		25. Was case referred to medical		26 5	Place of Death (C	perfo 1 Yes	rmed? 2 No	death?	
hysicia this cert	To Be	examiner? 1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpatient 2 ☐ ER.		nt 3 🗆 DOA Oth	ner: 4 🗌 Nursin	g Home 5 X Resid)
nding Path. r: After t	Certificate:	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	b. Time of injury	wor		28d. Describe h	ow injury occur	rred	
or Atte after de Directo I in by th	Certif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow		ber or Rura	l Route Number,
To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and	d/or invest	tigation, in my opin	ion, death occurr	ed at the time, date a	nd place, and di	ue to the ca	use(s) and manner stated.
To the I within 2 To the I comple	Me	only one) 3 Certifying Nurse Practitioner; To the best of my/s 29b. Signature and title of certifier	dowledge,	death occurred at			he cause(s) and 29d. Date sign		7
n		30. Name and accress of person who completed cause of death (item 23	/ M	D-20)629		8/	20	112
8h		GEORGE H. WATHEN, M.D., 11345	PEMBR	ROOKE SQU	JARE, SU	ITE 103,	WALDORE	MD	20603
Stat Registra	e ir	31. Date filed (Month, Day Coat 1 2012 32. Registrar's Signature	1. 4	ale					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2820 I Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Charles Edward Blake 15, 2012 August 5:20 a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles 8555 Bowie Road Nanjemoy Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min ^{Yea}(946 1 X M 2 □ F Months Jan. Day, 66 Director 226-64-3678 Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Virginia Richmond 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 329 South Cherry Street 23220 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Truck Driver Concrete Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Reuben Blake Roberta Ann Waid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reuben G. Blake Brother 8555 Bowie Rd., Nanjemoy, Md. 20662 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 18, 2012 Alexandria, Virginia Metropolitan Funeral Service 22. Name and Address of Facility
Williams Funeral Home, P.A. Signature of Funeral Service M00668 4270 Hawthorne Rd., 20640 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part 1. Enter th shock, or head Immediate Cause (Final disease or condition Onset and Death Physician estrue ons Medical resulting in death) Due to (s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as yes, outcome of pregnancy
Live Birth 2 Left Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence & Other (Specify Brothers 1 X Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖄 Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

25500

Point Lookout leandatown. UD gistrar's Signature

29c. License number

0050883

29d. Date signed (Month, Day, Year)

8/17/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State State Registrar	e of Marylan		tificate of D		nentai Hyç ı	Reg. No. 2 (112	28202		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day_	Year 20:2	3. Time of Death P 4: 05 M		
	Medic Examin		Katye Ruth BELL 4a. Facility Name (if not institution, give street and	number)		4b. City, Town, or	Location of Death	Hugus	7.00				
			Meritus Medical Cente	r			stown			ington			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h (, Year)	9. Birthpla Country	ace (State or Foreign		
	Director		463-20-6571 1 ☐ M 2 X Usual Residence of Decedent	88	Yrs.			Dec. 1	1923	Texa	.s		
	land f shov	tor	10a. State 10b. County	10c. Cit	y, Town or Loc	cation				100	d. Inside City Limits		
	28a-		Maryland Washington 10e. Street and Number		Hagers						1X Yes 2 □ No		
	ith the	ral				10f. Zip Code	0		10g. Citizen of	What Countr	y ²		
	eath w	Funeral		Decedent Ever in U.S	S. 13. V	2174 Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-		ce - Americar			
92	fter de	þ	1 Never Married 2 Married 1 I	ed Forces? Yes 2 X No s, Give		f Yes, specify Cubar ☐ Yes 2 【 No		Hican, etc.)	Bla Specifi	ck, White, et : Wh			
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212	withir rgiene ner tha t, the		12 4			Bookkeepe	r		(Office			
and	e filed ntal Hy ed oth even	To Be	17. Father's Name (First, Middle, Last)						Maiden Surname)				
Z	ould b		Lee Dolph Sheffield 19a. Informant's Name/Relationship (Type, Print)		19b Mailin	ng Address (Street a		Adell Ca		State Zin Co	nde)		
Ma	12 shoalth an 27 is r trau		Mark Bell - Son			Oak Stree					1		
ore,	of Hear		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal		Place of Dispo	sition (Name of natory or other place		Date	20c. Location				
im	Page ment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	HOITI OLALO		1 Cemeter	cy 8/25				Maryland		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur of Funeral Service Licensee	Tume	/ /	Name and Addres 15 E. Wil		innich l . Hagers			nd 21740		
Г			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure.										
	Physician/ Medical	7 1	Immediate Cause (Final disease or condition resulting in death)			11	Onset and Death						
1	Examiner		Di	e to (or as a consequ		NEPHA	ITIC						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	e to (or as a consequ									
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	cate be executed physician and the burial-transit	edical E	resulting in death) Last Do	`	,	TOPENI	iA.						
3760	ficate g phys		d		, , , , , , , , , , , , , , , , , , , ,								
Box 68	h certi tendin or use	ian/N	in the past 12 months?	s, outcome of pregna Live Birth 2 - Feta	al death 3	Ectopic pregnanc	y			ate of deliver	y Day Year		
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ds,	quires en sig ould b		PLEURAL EF	Lug and				1 🗆 '			ably 4 Unknown		
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed	CHRONIC	EFFLAON IC KIDNET			5	autor	24a. Was an autopsy performed? 1				
tal	sian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?				ace of Death (Chec						
Ę	Physic this or	၉	1 Ves 2 No	1 Inpatient 2 Date of injury	ER/Outpatier		4 U Nursing Ho	ome 5 Resid					
0 1	iding I th. After funer	cate		(Month, Day, Year)	injury	work'		28d. Describe fi	e how injury occurred				
visio	r Atter ter dea irector n by the	Certificate:	3 Suicide 6 Could not be	Place of Injury - At he building, etc. (Specif)		eet, factory, office		28f. Location (S City or Tow		per or Rural F	Route Number,		
Ö	pital o		29a. Certifier 1 Certifying Physician: To	the hest of my know	vledge death	occurred at the time	date and place, a	nd due to the ca	ause(s) and mar	nner as stated			
	ne Hos n 24 h ne Fun pletely	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practif	ne basis of examinatio	on and/or invest	tigation, in my opinio	n, death occurred a	t the time, date a	ind place, and d	ue to the caus	se(s) and manner stated.		
	Vithi Vom		29b. Signature and title of certifier			29c. License			29d. Date sign	ed (Month, D	ay, Year)		
			178		. 00-1 7		62006		8/23	1201	2		
_	77		30. Name and address of person who completed Wiredu, A	10 11111	o Mec	lical (inpus	Rd Hu	gersto	wnt	D 21745		
	Sta Registra		31. Date filed (Month UG 19)4 2012	32. registrar's Signa	atur	24)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rita Anna BLACKSTOCK MUCIUS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min Months Hours **Director** 205-14-8085 1 □ M 2X F 87 Pennsylvania July 8, 1925 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Williamsport Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be with 1 Funeral USA 16505 Virginia Avenue 21795 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates white Specify 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) homemaker her own home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Louis Smargiassi Mary Menna Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12591 Carol Ave., Greencastle, Pa. 17225 Cindy Blackstock - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/22/12 Cedar Lawn Mem.Park Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signalus of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNRAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Aterioventriular Block Ph_sician/ THIRD disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ight Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury use as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ó in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe 2 🗌 No Yes 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \(\text{Yes} 2 E No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner-of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After i Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 7060

Registrar
DHMH 17 Rev 06-2011

State

esh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kumar

egistrar's Signatur

MD

11116 Medical Ca

DHMH 17 Rev 1/2001

State

Registra

31. Date filed (Month, Day, Year)

AUG 2 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	-	artment of He			2111	2 28205	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	tilicate of De	auri	2. Date of Dea	Reg. No.		
	Physicia Medic		GEORGE M. F	BELL			Month AUG.	17, 201		
	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of De	ath	
-			6408 4th AVE. 5. Social Security Number 6, Sex 7, Age.	(In yrs. last birthday)	TAKOMA		O Detect Dist	MERY		
	Funeral Director		577-42-7879 1 M 2 □ F	76 Yrs.		Hours Min.	8. Date of Birth (Month, Day AUG • 3		irthplace (State or Foreign ountry) ARYLAND	
	nd how at	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	tarylar 8a-f sl tified	Director	MD. MONTGOMERY		AKOMA PARK				1 ¥ Yes 2 □ No	
	a or 2 be no		10e. Street and Number	II	10f. Zip Code			10g. Citizen of What (Country?	
	th with ms 23 must	Funeral	6408 4th AVE.		20912			U.S.A		
ယ	or ite	by Fu	11. Marital Status 1 ☐ Never Married 2 🛣 Married 12. Was Decedent Every Armed Forces? 1 ☐ Yes 2 🛣 N	0	Was Decedent of Hispa if Yes, specify Cuban, N		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
003	urs aft ural", al Exau	ted k	3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 1 No S	Specify:		Specify: W	HITE	
15-(72 ho n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during		ng	16b. Kind of Busines	s Industry	
212	within giene. er tha , the A		Elementary/Seconday (0-12) College (1-4 or 5+	,	O <i>NOT u</i> se retired) 1 EAT CUTTE F	R		SUPERM	ARKET	
nd	filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		18	8. Mother's Name	(First, Middle, I	Maiden Surname)		
Maryland 21215-0036	ould be d Men marke matic	-	IRVING BELL				CARRIE	MORROW		
Ma	12 sho aith an 27 is r trau		19a. Informant's Name/Relationship (Type, Print) SHARON A. BELL/WIFE	196. Mailir 6408	ng Address (Street and		·	MD. 20912	., ,	
ore,	of Head		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	20b. Place of Dispo		1	ate	20c. Location - City of		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	1	RS CREMATOR	RY 8-18-	-2012	RIVERDAL	E, MD.	
Bal	permi Depar Impo any ir		21. Signature of Funeral Service Licerisee	20 M00091 5	CHAMBERS TEST 5801 CLEVEI	JNERAL HO LAND AVE	OME & C	REMATORIUM RDALE, MD.	P.A. 20737	
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	he death. Do not ente	er the mode of dying, s	such as cardiac or	respiratory arre	est,	Approximate Interval Between	
~ F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	NCER					Onset and Death	
	Examiner			consequence on:						
	n **	Examiner	cause. Enter Underlying	contraduence uty:						
	and	Exan	Cause (Disease or iinjury that initiated events c.	consequence of):						
09	icate be executed I physician and s the burlar consit	edical								
876	tificate ng phy as the	Med	IF FEMALE:							
P.O. Box 687	death certificate be executed re attending physician and ed for use as the burlar consistency.	Physician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year	
Ö.	he dea y the a iched f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			WORL				
0 <u>.</u>	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but	in Part I.	23e. Did tol	pacco use contribute t	o use contribute to the cause of death?			
rds,	equires	ted	EMPHYSEMA				1 🕅 Y	Probably 4 Unknown		
OOe	has b	Completed					24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of	
<u> </u>	Physician: The law this certificate has al director, page 2 :	Be Co	25. Was case referred to medical		26 Place	of Death (Check	1 Yes		es 2 🗌 No	
Zita Zita	nysicia nis cer direct	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatien	t_2	_ Other			ence 6 Other (Spe	cify)	
Division of Vital Records,	al or Attending Pt s after death. il Director: After th ed in by the funeral		27. Manner of Death 1 X Natural 5 □ Pending (Month, Day, Value)	28b. Time of injury	work?		8d. Describe ho	w injury occurred		
Sior	Attend r death ctor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury	- At home, farm, stre		3 2 □ No	8f. Location (St	reet and Number or Ri	ıral Route Number	
N N	tal or, rs afte al Dire ed in t		building, etc. (Specify)	,	1	City or Town		and froute real floor,	
:	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the Ton the Funeral Director. After this certificate has been signed by the Completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check only one) 1	mination and/or invest	igation. In my opinion, d	death occurred at t	he time, date an	d place, and due to the	cause(s) and manner stated	
	withi	-	29b. Signature and title of certifier		29c. License nu		1	9d. Date signed (Mon		
	6				D0064	4983		AUG. 17,	2012	
			30. Name and address of person who completed cause of dea DR. KASHIF FIROZVI, M.D	th (Item 23a) (Type, P	rint) MEDTCAT. F	PARK DR	.SUTTE	200. STLVF	R SPRING, MD.	
	Stat Registra	•		Signature fact	J.	LANCE DIV.	, DOTTH	200, DILIVE	E DIRING FID	
			Charles Contraction							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\mathsf{Month}}{\mathsf{AUG}}$. 2012 REMIGO BAQUE 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death POTOMAC VALLEY NURSING HOME MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min APRIL 19 1 X M 2 □ F .1920 Director ECUADOR 579-52-1900 92 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3522 MANORWOOD DR 20782 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ŏ þ 1 Never Married 2 Married 1 X Yes 2 □ No Specify: ECUADORIAN Baltimore, Maryland 21215-0036 72 hours after "natural", 3 XWidowed 4 ☐ Divorced Completed Specify: WHITE Year or Dates injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) FOOD SERVER RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **SEGUNDO** BAQUE SENOVIA Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCRECIA BAQUE/SISTER 3522 MANORWOOD DR. HYATTSVILLE, MD.20782 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) 8-18-2012 4 Donation 5 Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of buria transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 No as been signed by the a 2 should be detached g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 욘 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Vatural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) sompleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical
3 Certifiin miner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

only one)

30. Name and address of pe

31. Date filed (Month, Day, Year)

AUG 20 2012

HESHMAT,

29b. Signature and

completed cause of death (Item 23a) (Type, Print)

M.D.

se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2401 RESEARCH BLVD., ROCKVILLE, MD.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012

			For State Registrar	State of Marylar		artment of tificate of		nd Mental Hy	ygiene 2 (112 28207								
	Physicia Medi		1. Decedent's Name (First, Middle, Las Alicia Barture	,				2. Date of D	eath /11 ^{Day} /201	3. Time of Death 8:38 pM								
Market .	Examir		4a. Facility Name (if not institution, give Holy Cross Hos			4b. City, Town, o	r Location of		4c. County Mont	y of Death								
	Funeral Director		5. Social Security Number 6. S 220-75-3646 1 Usual Residence of Decedent	ex	last birthday) Yrs.	If Under 1 Year Months Days			**************************************	Birthplace (State or Foreign Country) Peru								
	aryland ha-f shov ified at	ector	10a. State 10b. County MD Freder		ty, Town or Loc rbana	cation	•			10d. Inside City Limits 1 ☐ Yes 2 No								
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 3511 Ward Lane			10f. Zip Code 2170	4		10g. Citizen of Peru									
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates.	i ii			n? (Specify Yes or No Puerto Rican, etc.) Peruvian	1 5.00	ce - American Indian, ck, White, etc.								
21215-0036	ed within 72 hou Hygiene. other than "natu ent, the Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) home maker					stic								
Maryland	12 should be filed v lith and Mental Hyg 27 is marked othe r traumatic event,	To Be	17. Father's Name (First, Middle, Last) Adolfo Barture	n Fernandez				s Name (First, Middle ila Coro	*	,								
	and 2 shoul Health and I tem 27 is ma		19a. Informant's Name/Relationship (7) Katia Ayala –		19b. Mailin 351 1			or Rural Route Numb Jrbana,										
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.	Removal from State	Place of Dispos cemetery, crem 1 Sou]	atory or other plac	^{Ce)} 8,	Date / 16 / 12		- City or Town, State								
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens Wanda C.	Balon CC036	1 W.	Name and Addre	ss of Facility	3447 14t neral Ho	h St NW me	Wash DC 20010								
Mary and Mar	Physician/ Medical Examiner	miner	23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, to cause. Enter Underlying Cause (Disease or injury	a	otic uence of: Pneu	Shod monic	<u>k</u>	Cance		Approximate Interval Between Onset and Death								
092	ficate be executed g physician and as the burial transit	by Physicia									that initiated events resulting in death) Last	Due to (or as a consequent	uence of):		281			
Box 68	death certi			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Dai	te of delivery nth Day Year							
ds, P.O.	The law requires that the ate has been signed by the page 2 should be detach		Part II. Other significant conditions co	entributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.			ribute to the cause of death?								
I Recor	nysician : The law re nis certificate has be I director, page 2 sh	e Completed	25. Was case referred to medical	7		00.81			psy prmed?	Were autopsy findings available orior to completion of cause of death?								
Division of Vital Records,	To the Hospital or Attending Physician: In the Funeral Director: After this certifica completely filled in by the funeral director,	Certificate: To Be	27. Manner of Death 1	Hospital: 1 Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatient 28b. Time of injury	3 DOA Other	er: 4 □ Nursi y at	28d. Describe i	esidence 6 Other (Specify) be how injury occurred									
Divisi	ital or Atturs after de ral Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined					City or Tov	n (Street and Number or Rural Route Number, Town, State)									
	the Hosp nin 24 hor the Fune npletely f	Medical	(Check 2 Medical Examir only one) 3 Certifying Nurs	ician: To the best of my knowler: On the basis of examination e Practitioner: To the best of m	and/or investig	gation, in my opinic	n. death occur	red at the time, date a	and place, and due	to the cause(s) and manner stated.								
	P 100 2		29b. Signature and title of certifier	my Verna	POL	29c. License D00	67279		29d. Date signed 08/14/	(Month, Day, Year) 12012								
_			30. Name and address of person who consume and address of person who consume a supplied to the	rsamy Veera	ppan 1		rest (Glen Rd.	,Silver	20910 Spring,MD								
	Stat Registra	e Ir	31. Date filed (Month, Pay, Year) AUG 15 201		. par													

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a.pt. II.25,27,28a-f,per me. 2938 4-24-13 sm. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eugene Billups, Jr. 2 145PM 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death plata Civi sta Medica Co Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 941 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 248-66-6705 Director 70 1 **X** M 2 □ F August 19, South Carolina Usual Residence of Decedent 28a-f shov with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director **Maryland** 1 X Yes 2 No Charles White Plains 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3276 Sutherland Court 20695 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Yes 2 🗶 No If Yes, Give ō Black, White, etc. 9 1 Never Married 2 X Married 21215-0036 1 Yes 2 No Specify: "natural", **Black** Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than ementary/Secondary (0-12) College (1-4 or 5+) injury or other traumatic event, the 12th grade Bakery Manager Safeway Foods, Inc. Be Maryland 1 and 2 should be filed of Health and Mental Hitem 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eugene Billups, Sr. White Azalea 9a. Informant's Name/Relationship (Type, Print)

Dorothy Ann Reid Billups (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3276 Sutherland Court; White Plains, Maryland 20695 Brian Eugene Billups (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State emetery, crematory or other place) Aug.2,2012 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland signature of Funeral Servi and Address of Facility R. N. Horton Company Morticians, Inc.: 600 Kennedy Street, N.W.: Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Schemic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Neck Injuries with complications 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 🔀 No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 2 X Accident subject fell the Investigation 2002 unk 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Yard 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3276 Sutherland Ct. White Plains, MD. filled in by 4 Homicide determined Hospital 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my incomedation of the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely f 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) alna 27/12 DO050 883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2012 28209											
		neg notes										
		1. Decedent's Name (First, Middle, Last) ysician/ Modical Sylvia E. Bailey 2. Date of Death Month August 8, 2012										
	Medic xamin		Sylvia E. Bailey 4a. Facility Name (if not institution, give street and number)	4b. City	. Town, or	Location o		lugust (4c. County of	17:37 M		
1			Fort Washington Hospital			Wash		on	,	ce George's		
	neral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under		If Under 2 Hours		8. Date of Birth (Month, Day,		. Birthplace (State or Foreign Country)		
	ector		579-18-3604 93 Usual Residence of Decedent	Trs.			[(Oct. 5,	1918	DC		
land	dat	tor	10a. State 10b. County 10c. City, Town	or Location						10d. Inside City Limits		
Mary	otifie	Director	Maryland Prince George's			Fort	Wash:	ington		1 🏻 Yes 2 □ No		
ith the	st be r		10e. Street and Number 9105 Ivahnoe Road	10f. Zi	p Code	20	744		10g. Citizen of Wha United			
and 21215-0036 be filed within 72 hours after death with the Maryland antal Hygiene.	er mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Dece	dent of His	spanic Orig	in? (Spec	ify Yes or No-		American Indian,		
36 after d	amine	þ	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	If Yes, spe		, Mexican,	Puerto R	lican, etc.)		White, etc.		
Maryland 21215-0036 2 should be filed within 72 hours after that Mental Hygiene.	atural cal Ex	Completed	3 X Widowed 4 Divorced Year or Dates.							Black American		
215 n 72 h	Medi	dm	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business Industry US Department of			
21 within ygien	it, the	Be Co	2	C	leric				State			
Maryland Should be filed to hand Mental Hyg	ever	To B	17. Father's Name (First, Middle, Last) Fredy Martan			18. Mothe		,	flaiden Surname)			
aryl	ımatic		Fredy Martan Francis Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)							Zin Codel 2271		
d 2 stratth a	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.			l05 Ivar					ngton, Ma	20/44		
of He			20a. Method of Disposition 20b. Place of	Disposition (Na y, crematory or	me of	- 1	D:	t 17,	20c. Location - Cit	y or Town, State		
Baltimore, bermit. Page 1 and Department of Hea			4 □ Donation 5 □ Other (Specify) Harm	ony Cem				2012	Landove	r, Maryland		
Bal permir Depar	any ir		21. Signature of Funeral Service Licensee M00560	22. Name a 4001			Dec		neral Horington,	•		
			Approximate Interval Between									
Priysi	cian/ dical	3 4	Immediate Cause (Final disease or condition resulting in death)	a						Onset and Death		
	niner		Due to or as a consequence of	of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of the conseque	of):								
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3760 ficate b g physi	as the		_ d									
x 687 h certific	r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	3 🗆 Ectopic	pregnancy	/			23d. Date o	,		
Box e death c	should be detached for use as	Physician/M	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (s	pecify)				Month	Day Year		
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'Ital sician certifi	rector	m	25. Was case referred to medical examiner? 1 Yes 2 PNo Hospital: 1	Other	ce of Death							
Of V 3 Phys or this	eral di	e: To	27. Manner of Death 28a. Date of injury 28b. T	ime of	OA 28c. Injury	4			nce 6 Other (S	(pecify)		
On on ending sath.	he fun	ficat	2 Accident Investigation	njury M	work?	y Yes 2□I	No					
Division of Vital Records, tal or Attending Physician: The law requires 's after death.	in by t	Certificate:	3 Suicide 6 Could not be 4 Homicide determined determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)									
Spital (filled		29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, c	death occured a	the time	date and n	lace and	due to the caus	se(s) and manner a	s stated.		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific	тріете	Medical	(Check 2 Medical Examiner: On the basis of examination and/o only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	r investigation, in edge, death occu	my opinior	time, date	curred at the	he time, date and and due to the	d place, and due to cause(s) and manne	the cause(s) and manner stated. er as stated.		
			29b. Signature and title of certifier with the will will be the wi		カ っ	520k	6	2	Augun L	-9, 20/2		
- 4	Jin		(Check only one) 3 — Redical Examiner: On the basis of examination and/only one) 3 — Certifying Nurse Practioner: To the best of my knowledge. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Item 23a). Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Type, Print)	ng h	n Ru	md,	Fut	WASHIYI	h. mo		
Re	Stat gistra	e ir	31. Date filed (Month, Day, Year) AUG 1 4 2012 32. Registrar's Signature	inke								

DHMH 17 Rev 7/2009

12-05862 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Anthony J. Boatwright 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Anthony J. Boatwright **Medical Examine** 0020 hrs August 6, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Temple Hills Road & Fisher Road Temple Hills Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Wash 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days 578-25-1673 Hours Director 1-6-1994 18 Country) D.C. 1 X M 2 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County D.C. Washington 1 X Yes 2 No notified at once, more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5804 Foote St. N.E. Apt #2 20019 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Yes Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. <u>≲</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 127 is marked other than " Student Private 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Donna Boatwright 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5804 Foote St. N.E. Apt #2 Wash D.C.20019 Donna Boatwright (Mother) ent of Health a nt: If item 27 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8-16-12 Waldorf MD. Heritage Cemetery 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility Hunt Funeral : 908 Kennedy St. N.W. Wash, Home D.C. 20011 CC353 rung 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical a. Gunshot Wound of Torso Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed cal icate has been signed by the attending physician a page 2 should be detached for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 V Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject shot FOUND: Natural Pending 1 Yes 2 V No death. filled in by the Director: Aug 6, 2012 0014 hrs 2 [Accident To the Hospital or Att within 24 hours after do To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 | | Could not be Suicide or Town, State) Temple Hills Road & Fisher Road, Temple Hills, MD determined (Specify) Sidewalk 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 6, 2012 00 de aude ME 30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31, Date filed (Month, Day, Yea Registrar's Signa State AUG I Registrar

DHMH 17 Rev 1/2001

OOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2821 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUG". 11, 2012 Physician/ CELESTINA BETTON 6:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VILLAGE AT ROCKVILLE MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days Min MAR. 3, 1925 GUYANA 134-50-9607 Director 87 1 □ M 2 🔀 F permit. Page 1 and 2 should be filed within 72 hours after used in minimum. Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 25a or 28a-f show important if items are not items and items are not items. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. MONTGOMERY ROCKVILLE X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 VEIRS DRIVE 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SEAMSTRESS HOME CARE 12 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JAVEST** RISHTON ELETHIA RICHARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL BETTON- SON 4502 HOWARD RD., BELTSVILLE, MD.20705 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State METROPOLITAN CREM! 8/18/12 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW 21. Signature of Funeral Service HYSONG CO. CC0367 WASHINGTON DC 20007 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, neach line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final tension Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to dical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Unursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident
☐ Suicide
☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00064624 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pockerile, 9701 Dr. MD 20850 ANDEED SHARMA Veis 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State AUG 1 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Christine Ardette 6:44 pM Shipe Cover August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Rohrersville 3018 Kaetzel Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Min. March 5 1 M 2 TX F Hours Year 1929 West Virginia 83 Director 579-34-8614 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rohrersville 1 Yes 2 X No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3018 Kaetzel Road 21779 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 X Married Completed by 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Clerk U. S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Poff Elliott Cannaday Gay Dewey Lura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3018 Kaetzel Road, Rohrersville, Maryland 21779 Richard V. Cover/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery Aug. 20, 2012 Frederick, Maryland 21. Signat Parvice kipe 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Cause (Final Onset and Death ₽nysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Myrlogenous Sequentially list conditions, if any, reading to in mediate Examiner if any, leading to in modate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-transi To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier E Kay 11 Mditt 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

OVLEANS

Km

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month O S 3:38 AM - 3013 Charles W. Chapman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Coastal Hospice at the Lake If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 052-28-8071 **Director** 1 X M 2 □ F New Jersey 01 14 1933 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 □ No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 30051 Stoneybrooke Drive I Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Law Lawyer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked ot ၉ Lillian Snyder Charles Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30051 Stoneybrooke Dr., Salisbury, Maryland 21804 Nancy Chapman wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08 16 2012 Salisbury, Maryland Salisbury Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee HOIIOWAY Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UCAYS Immediate Cause (Final Pulmonary Chronic Obstructive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ō the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 D Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) H68413 30. Name and address-of person who completed cause of death (Item 23a) (Type, Pint). Box 1733 Salisbury, MD 2/802 31. Date filed (Month, Day, Year) State 16 2012 AUG Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1557 Zabeth 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death REGIONAL MAGIOSI Centa 1comico TENIASULA SAX 136414 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 13-22-5290 1 □ M 2 😿 F -1928 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 X Yes 2 No tcco mack hincoteague 10e. Street and Number 10 Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 ☐ Yoo Specity: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Naitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be to Department of Health and Ments Important: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonaucii Daugh orena a Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other -18-2012 4 Donation 5 Other (Specify) Cemeter Hall 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chincoteague, huzh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ iamous Carcinan Cell disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending a IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No ed by the a detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown atter this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 XN 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 Yes Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{\text{Residence}} \) 1 \(\text{\text{Other}} \) 2 \(\text{\text{Other}} \) 2 \(\text{\text{Other}} \) 1 \(\text{\text{Constitution}} \) 2 1 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred in 24 hours are: the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check-3 only one) To the within 7 the 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) amuelle 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

28216

		•	State Registrar			,	C	ertificate of	Death			Reg. No	0.		
	Physicia	n/	1. Decedent's Name (First,		,	1.					2. Date of De		ev oo Year		3. Time of Death
J. 1865	Medic	al	Sylvia V					1			August				:35 a ™
	Examin	er	4a. Facility Name (if not ins 3612 Link			iber)		4b. City, Town, Cambr		of Death		40	o. County of De Dorc		er
2.7	Funeral 5. Social Security Number 6. Sex 7. A						. last birthday	8. Date of Bir				e (State or Foreign			
	Director		214-07-8886		1 □ M 2 🙀 F	96	Yrs.	Months Days	Hours	Min.	(Month, Da Aug. 2			ary1	
	nd now st	ŗ	Usual Residence of Dece 10a, State 10b, 0			10c. (City, Town or	ocation							Inside City Limits
L	arylar ia-fsł ified ź	ecto		orche	ster		,	Cambr	idge					- 1	1 ☐ Yes 2 🛣 No
7	or 28	Dir	10e. Street and Number					10f. Zip Code				10g. C	itizen of What (Country?)
2	with with ust b	Funeral Director	3612 Link	wood	Drive				2161	3			USA		
3	death item: ner.m	Fun	11. Marital Status		12. Was Dece Armed Fo	rces?	J.S. 1	B. Was Decedent of H If Yes, specify Cub	lispanic Or an, Mexica	igin? (Spe	cify Yes or No- Rican, etc.)		14. Race - An Black, Wh		ndian,
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	ed by	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Di		1 ☐ Yes If Yes, Giv Year or Da	e		1 ☐ Yes 2 🛣 No					Specify: W		2
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رن ک	and 2.		Linda Phill	ips	daug			Linkwood	Driv						
Baltimore,	age 1 ant of H		20a. Method of Disposition 1 K Burial 2 Crer			State	cemetery, c	position (Name of ematory or other pla er Mem. P		8/23	Date 2 /1 2		ocation - City		
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			23a. Part 1. Enter the dise shock, or heart failure			ch line.			1		r respiratory ar	rest,		Inte	proximate erval Between
- 1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		a	Congo	stive	heart for	aclus.	R				On	nset and Definition
Alley.	Examiner		resulting in death,		Due to	or as a donse	equence of):	heart to	tin					1	1000
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	ificate be executed g physician and as the burial-transit	Medical Examiner	resulting in death) Last	ı	Due to	or as a conse	equence of):							1	
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.89	ath certifi attending I for use a		IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, out	come of preg	nancy						23d. Date of d	lelivery	
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P.O.	es that the dea signed by the a I be detached i	Phy	g Unknown Part II. Other significant c	onditions (esulting in th	underlying cause g	iven in Part	- 1	230 Did to	obacco	use contribute	to the co	ause of death?
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Records,	v requires been signatures should b	olete									24a. Was		24b. Were a	autopsy 1	findings available
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of Vital	hysicia this cert	잍	1 Yes 2 X No					ient 3 DOA Oth	4 ∐ N				6 ☐ Other (Spe	ecify)	
n of	ding Phy h. After thi funeral	Certificate:		Pending	1	of injury th, Day, Year)	28b. Time injur	wor	ryat k?]Yes 2.⊑		28d. Describe h	now inju	ry occurred		
Division	Atten r deat ector: by the	rtific	3 Suicide 6 🗆	Investigation Could not determined	be 28e. Place	of Injury - At	home, farm,	street, factory, office	165 2				nd Number or F	Rural Rou	ute Number,
Divi	tal or	ol Ce	4 El Homioldo		buildi buildi	ng, etc. (Spec	cify)				City or Tou	vn, State	e) 		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check 2 Me	dical Exan	niner: On the bas	is of examinat	ion and/or inv	h occurred at the time estigation, in my opin	ion, death o	ccurred at	the time, date a	and place	e, and due to th	e cause(s	
	To the within 2 To the сотрые	Ž.	only one) 3 L Ce		rse Practitioner	To the best of	of my knowled	ge, death occurred at 29c_Licens		ate and pla	ice, and due to t		e(s) and manner ate signed <i>(Mor</i>		
	Oi I		1/21	4	14-5			200	059	931		2	8/20/12		
	1		30. Name and address of r	erson who	completed caus	e of death (Ite	em 23a) (Type	, Print)	າ /	7		1		11-1	11000
	- Ct-		31. Date filed (Month, Day,	Mar Year)	200	434 egistrar's Sigi	nature #	Vernon	Kd	Triv	ncess	H	ine 1	119	21853
	Stat Registra		AUG 2	1 20	12	ر ساس	8. A	who							

death certificate be executed Box 68760 P.0. Records, has Division of Vital Hospital or Attending Physician:

attending physician and for use as the burial-tran signed by the a within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, To the I within 2 To the I

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifier

My/MD Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL, MD 1604 MARKET ST. POCOMOKE CITY MD 21851.

City or Town, State)

29d. Date signed (Month, Day, Year)

8/20

SHARAD R 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

62172

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 2:00PM JAMES SYDNEY CHESLEY, SR. AUGUST 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES MEDICAL CIVISTA Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 214-18-8452 **Director** 1 XM 2 □ F OCTOBER 13, 1920 MARYLAND 91 Usual Residence of Deceder 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f CHARLES 1 Yes 2 X No MARYLAND INDIAN HEAD 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a UNITED STATES 4360 LIVINGSTON ROAD 20640 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 'natural", or 1 Yes 2 No 1942-Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 1945 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) ORDINANCE AMMINITION & EXPLOSIVE OPR FEDERAL GOVERNMENT 9TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM ALEXANDER CHESLEY MATTIE JOSEPHINE SWANN CHESLEY and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 4360 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 EVA S. CHESLEY / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MARYLAND VEITRAN CEMEITRY AUGUST 24,2012 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) LIDIA C. THORNTON JOHNSON MOO583 THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🗗 No Hospital Other: မ 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be ☐ Suiciue
☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number

Ba +1

MAH

Registrar

DHMH 17 Rev 06-2011

CENNA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-D.

2-06211		Please Type or Print in Black					gible	9.	
Runette P. Cler	neni	Otate of Marylana / De	•		nd Mental H	lygiene		201	2 282
		Registrar	Certific	cate of Death			Reg. No.	201	
Physic		Decedent's Name (First, Middle, Last)				Date of De Month	ath Day	Year	3. Time of Death
Medical Exam	iner	Tarkhouse of	emen			August 1	8, 201	2	0716 hrs
		4a. Facility Name (if not institution, give street and number)			r Location of Deat	h		. County of Death	
		Suburban Hospital		Bethesda	- I	T		Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In.)	yrs. last bi	rthday) If Under 1 Ye. Months Day			irth (MM/	DD/YYYY) 9. Birl Foreig	
Director		163-30-1122 1 M 2 F 76		Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dec. 3	1, 1	935 Wass	hington, Do
A		Usual Residence of Decedent 10a, State 10b, County 10c.	Cit. Taur	n or Location					
W 209		10a. State 10b. County 10c.	City, Towi	TOI LOCATION					10d. Inside City Limits
Maryland 28a-f show 1 at once.	ģ	MD Montgomery	Silve	er Spring					1 Yes 2 X No
Mary r 28s	Director	10e. Street and Number		10f. Zip Code			10g. Citi	zen of What Cour	ntry?
hours after death with the Maryland 'vatural', or items 23a or 28a-f sho Examicer must be cotified at once		531 Randolph Road, Apt. 210		20	0904		US	A	
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	Funeral	1 Yes 2 X N	No			, , , , , , , , , , , , , , , , , , , ,			
s afte iral"	و	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete:	0 140:	1 Yes 2 No				SpecifWhite	
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15-0036 filed within 72 hours after I Hygene. do ther than "oatural", t, the Medical Examiner.	Completed	17. Father's Name (First, Middle, Last)			18.Mother's Nam	First Middle	1		
21215-0036 uld be filed within 7 Mental Hygiene. marked other thao	Bec	Kenneth Wilkie Parkhouse				fae Mon		ourname,	
2121; uld be fil Mental F marked	ToB	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Stre				ty or Town State	Zin Code)
∪ % 5 #		Victoria M. DiBella/Daughter		410 Moleton					
- 명품 등		20a. Method of Disposition 2	0b. Place	of Disposition (Name of ce		Date		ocation - City or	Town, State
OF it of I it of I it of I		1 X Burial 2 Cremation 3 Removal from State	ate c	tory or other place) I Heaven	Αι	ig. 24, 2012	l	_	
Baltimore, permit. Pages I as Department of Hee Important: If ite	- 3	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Cemetery	o of Facility	2012	Si	lver Spr	ing, MD
Balti Permit. Departir Imports		21. digitator of Furieral Service Licensee		22 Name and Addres	Collins	Funera	al H	ome Inc.	
Physician	× . /	23a. Part I. Enter the disease, or complications that caused the de	eath. Do n	500 Univers	such as cardiac	or respiratory ar	Silv	er Sprin	MD 2090 Approximate Interva
/Medical		failure. List only one cause on each line.			,		,	ord or 110011	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence)	ce of):						Deatil
			00 01).						
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	ce of):						
0	Ë	cause. Enter Underlying Cause (Lisease or injury that initiated c.	_						
B. H.	Examiner	events resulting in death) Last Due to (or as a consequence	ce or):						
executed in and ul - transit	ig E	d. UNPENDED AMENDED							
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876 ificate ig phy s the	₹	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	-		Ectopic pregna	ancy		. Date of delivery Month D	ay Year
K 68	cia	past 12 months? 4 Pregnant at time of	A de mile	Fetal death 3 Other (Specify)		incy		Wiorian D	ay real
Box 68760, e death certificate be e the attending physicia ed for use as the buria	Physician/Medi	1 Yes 2 No 9 Unknown g Unknown		0.113, (12,213.),					
d by 1		Part II. Other significant conditions contributing to death but n	ot resultin	g in the underlying cause of	given in Part I.	23e. Did t	obacco u	ise contribute to t	he cause of death?
, P.C res that signed be deta	d by	Hypertensive Atherosclerotic Cardiovascular I	Disease			1 Ye	s 2 🗸	No 3 Proba	ably 4 Unknown
ords w requi	Completed					24a. Was			opsy findings available
e law te has ge 2 s	Ē					perfo	rmed?	death?	
tal Rec	ပိ	25. Was case referred to medical		26 Place	of Death (Check	1 Yes	2 NO	1 Yes	2 No
of Vital Records, og Physicleo: The law require the true certificate has been signeral director, page 2 should be	O B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	✓ ER/O		0.0		Resider	nce 6 Other:	
iog Phy. After th	-	27. Manner of Death 28a. Date of Injury			ry at Work?	28d. Describe			
ion (tendio	Certification:	1 Natural 5 Pending Aug 17, 2012	210	0 hrs 1	Yes 2 ✓ No	Passenger	auto a	uto collision	
ivision or Atten after death Director:	밀	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	At home, fa	arm, street, factory, office b	ouilding, etc.	28f. Location (Street ar	d Number or Rur	al Route Number, City
Div pital or ours afte ceral Diu	뒫	Suicide 6 Could not be determined (Specify) Local St	treet			or Town, S Damascus Ro		Laytonsville Ro	oad, Laytonsville, M
	2	29a. Certifier 1 Certifying Physician: To the best of my know		ath occurred at the time. da	ate and place, and		_		
To the Hos within 24 h To the Fus completely	edical	one) 2 Medical Examiner: On the basis of examination and manner stated.							
_	Æ	29b. Signature and title of certifier		29c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
10		1)-7)		O.C.I	M.E.		Augi	ust 19, 2012	
		30. Name and address of person who completed cause of death (I	Item 23a)						
		Donna M. Vincenti, MD Assistant Medical Ex		900 W. Baltimore	Street, Baltin	nore, MD 21	223		
S	ate	31. Date file Worth, Cay Year 1012 32. Registrar's Sign	pature						
Regis	trar	AUG ZU ZUIZ Seneur B	7. 14	artis.					

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year August 16, 2012 08:47 A M Roberta A. Carroll /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11/25/1939 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director 72 Pennsylvania 204-30-0763 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Mudical Evaluiner must be notified at TX Yes 2 □ No Director Maryland Prince Georges New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20784 or Items 23a 6208 87th Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after c nent of Health and Mental Hygiene. int: If Itam 27 is marked othar than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Visiting Nurses Registered Nurse **Association** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Robert Thunell Rita Hergenroder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if Itam 27 is any injury or othar tra once. Martin Carroll (Husband) 6208 87th Ave. New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Other (Specify) Chesapeake Crematory 08/18/2012 Beltsville, Maryland neral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature 9013 Annapolis Rd. Lanham, Maryland 20706 and I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician myo Card disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ίο Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Heart failure 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 2**X** No Hospital or Attanding Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No Months | Inpatient | 2 □ ER/Outpatient | 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of c 29d. Date signed (Month, Day, Year) Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr #313 Greenbelt,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2

0 2012

Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month William <u>1:4</u>4 A_M August -annon 12 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death 8601 BOCKLEY DRIVE WASHINGTON PG Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 578-42-8339 1 XM 2 □ F 78 02/01/1934 Usual Residence of Decedent SC show 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No PG FT. WASHINGTON 10e. Street and Number ō must be r 10g. Citizen of What Country? 23a Funeral 8601 BOCKLEY DRIVE 20744 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married ☐ Yes 2 🌠 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 12 th College (1-4 or 5+) MECHANICAL ENGINEER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked ည CLARENCE CANNON EDNA BRACEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH SHERMAN/ DAUGHTER 2247 RATTAN CT., BRYANS ROAD, MD 20616 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 Department of Important: If It any Injury or o XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/17/2012 SUITLAND, MD 21. Signature A.F. neral Service Ilcens 22. Name and Address of Facility POPE FUNERAL HOME, P.A. appe 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. MALIGNANT NEOPLASM OF THE COLON Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to for as a connectioned of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ in the past 12 months? Month Day Year Pregnant at time of death ed by the at detached for 1 Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after σσαυ...

To the Funeral Director: Α 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANP-BC

MELONIC REYNOLDS,

31. Date filed (Month, Day, Year)

ACO00 937

1801 MCCORMICK DR., STE 180, LARGO, MD 20774

Angust 15 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clarice Campfield 2012 12:20P M 08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 🗆 M 2 🔀 F 578-42-2694 88 07-01-1924 Wash., D. C. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 XYes 2 No Hyattsville MD Prince Georges ò 10f. Zip Code 10g. Citizen of What Country? Funeral 6842 Standish Drive USA 20784 and 2 should be filed within 72 hours after death wealth and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. "natural", or 1 Never Married 2 Married 21215-0036 Yes 2**½** No **Black** 1 Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Midwife Midwife Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ္ Maude Hamilton William Green 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Campfield (Daughter) 20716 Maryland Bowie, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem.Park 08-16-2012 Harmony Landover, Ralph Williams, II Funeral Service, 5202 PrincetonsDelightDr., Bowie, MD 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as contained in a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for sels consequence of, burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed' 2 🗌 No Yes 2 No 1 Tes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2-1 No 1 🗌 Yes Other: ဂ 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director; At 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner nd title of certifier 29b. Signature 29d. Date Signed (Month, Day, Year) Registrar

State

Registrar

31. Date filed (Month, Day, Year)

2 2012

32. Registrar's

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ FOr	ertificate of Death	aı myglen Reg. N	0010	28224
	Physici	an	1. Decedent's Name (First, Middle, Last)	M	ate of Death lonth uq 9 2	012	3. Time of Death
1	/Medio	al	John Henry Craft Jr 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	3:20 A M
	EXAMINI	lei	Heartland Nursing Home	Adelphi	1	rince G	_
	Funeral Director		5. Social Security Number 244-46-9780 6. Sex 18 M 2 F 7. Age (In yrs. last birthda; 79 Yrs.	/) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. 8. Days Ap	ate of Birth Month, Day, Yea Til 9	1933 NO	place (State or Foreign intry)
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
	e Mary 3a-f sh	Director	DC Washingt	con			Yes 2 No
	ath with th	ral Dire	10e. Street and Number 5502 Foote St NE	10f. Zip Code 20019	U.	S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exactions count to confine a sonce.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Young of Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	es or No- , etc.)	14. Race - Ameri Black, White, Specify: B	
15-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Gi.	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Ir	ndustry
212	withir jiene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	nting Supervisor	G	overnme	ent
Maryland 21215-0036	uld be filed Jental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) John Henry Craft Sr	18. Mother's Name (First Willie C	t, Middle, Maide Chorpin		
, Mary	and 2 shores alth and 10 sealth and 10 sealt		Eleanor Conway Craft 550		hingto	on DC 2	0019
Baltimore,	Pages 14 ment of He ant: If Iten ury or oth		4 Donation 5 Other (Specify) Riverg	position (Name of emalory or other place) ale Park ale Park 201	2 Riv	Location - City or T rerdale	Mđ
Balt	permit. Departi Import. any Inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility ${ t McLau}$	ighlin shingt	Funeral on DC 2	Home 0020
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		piratory arrest,		Approximate Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	MARY HAKES			
	Examiner	Ļ	Sequentially list conditions, b. MYCOSDIAL	INFARCTION		-	
	uted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	OF LUTUS		110	
68760,	eath certificate be executed attending physician and for use as the burial-transit	al Exa	resulting in death) Last Due to (or as a consequence of): PLO STATE	ANCER			
		Medical			1		
Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Set within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Physician/N		Ectopic pregnancy Other (specify)		23d. Date of delige Month	very Day Year
۰, ح.	ires that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ord	w require s been sig should b				1 🗆 Yes	2K No 3 □ Pro	bably 4 Unknown
I Rec	Attending Physician: The law r sr death. ector: After this certificate has be by the funeral director, page 2 sh	Completed			24a. Was an autopsy performed? I □Yes 2 🔼N	prior to c death?	topsy findings available ompletion of cause of 2 □No
₹	siclan certifi rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Che	-		
0	g Physer this leral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. D	5 ∐ Residence Describe how inj		ify)
Sior	eath. or: Aff	catio	2 Accident investigation	M 1 □Yes 2 □No			
Division of	tal or Attencrs after death al Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Lc	ocation (Street City or Town, Sta	and Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, de 2 ★ Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at	the time, date a	and place, and due	to the cause(s)
		2	29b. Signature add title of certifier MD	29c. License number	Au	Date signed (Month),2012
	37%		30. Name and address of person who completed cause of death (Item 23a) (Type CTOL THE CONTROL THE AMERICAN TRANSPORTED TO THE CONTROL THE	Print)	REENE	selt mi	0,2012 9RY LAND
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 5 2012 32. Registrar's Signature	back			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28225 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 7, Day 2012 Year Physician/ Betty Louise Cheatham 11:17A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Year) 249-66-8482 71 **Director** 1 □ M 2 🖺 F 12/5/1940 South Carolina 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Washington D.C. 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20012 U.S.A. 859 Venable Place, N.W. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. Black 1 X Never Married 2 Married o, þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working c than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) WASA Deputy Director Ith and Mental Hygien 27 is marked other the rraumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marian Hammond Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 11515 Lockhart Place Silver Spring, Md. 20902 Department of Health ar Important: If item 27 is any injury or other trau Thomas Marshall, Jr. (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Ridge Hill Bapt. Church 8/17/2012 Ridge Spring, SC 4 ☐ Donation 5 ☐ Other (Specify) S un ture of Funeral Service Lic 22. Name and Address of Facility Marshall-March Funeral Home N.W. Washington, D.C. 20011 9th Street, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ (0/0/N/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): physiciar Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe tastatic Colon 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy certificate has 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? 1 \quad Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Investigation 24 hours after deat Funeral Director; 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 2 To the I 12m

> State Registrar

29a. Certifier

(Check

only one)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

se Ta Koma Park

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Galo Cedeno 7:27AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice At the Lake comico If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 109-68-2592 Country) Director 1 X M 2 D F 50 Usual Residence of Decedent Ecuador shov 10a. State 10b. County ortent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 sho Injury or other treumetic event, the Madical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 728 Waverly Dr. 21801 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black White etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No If Yes, Give 1 ¥ Yes 2 □ No Specify: Completed 3 Divorced Ecuador White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end Mental Hygiene. is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Line Worker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Department of Health and 2 should be Department of Health and Menta Importent: If item 27 is marked eny Injury or other treumetin and Injury or other treumetin and Injury or other treumetin and Injury or other treumetin ည Galo Cedeno Sonnia Savinovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonnia Garcia/Mother 728 Waverly Dr., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place of Springhill Memory 20c. Location - City or Town, State Date 7 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specificombment 8/18/2012 Hebron, MD 21. Signature of Furteral Savice Licensee 22. Name and Address of Facility
Stewart Funeral Home by Holloway and Downey, P.A.
821 West Rd. Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Industying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam or Attending Physicien: The lew requires that the death certificate be executed the ettending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year Yes 2 □ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? ᅙ Records, Completed been si 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s perform 2 1 No Yes 2 No 1 Tes Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) 2 1 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 🗆 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 5 Pending injury To the Hospital or Attendin within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fur Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29c. License number who completed cause of death (Item 23a) (Type, Print) ASTERN State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland	d / Department of I		lental Hyg	giene	2 2022
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of L	Death		Reg. No. ZUI	2 28227
والمتازير	Physicia Medi	cal	Tia Mikayla Collins			2. Date of Dea	Day 2016	
	Examir	ner	4a. Facility Name (if not institution, give street and number) THIN SULA SULANDER 6. Sex 7. Age (in vrs. la.	Perter.	SAU/SOU/	0.00	-	MIOU
9	Funeral Director		5. Social Security Number n a Usual Residence of Decedent 6. Sex 1 M 2 M F	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	hirthplace (State or Foreign Country) Mary Jand
	ryland I-f shov ied at	ctor		, Town or Location			•	10d. Inside City Limits
:	the Ma or 28a e notif	Ei.	Maryland Wicomico Sal	10f. Zip Code			10g. Citizen of What C	1 X Yes 2 No
3	ns 23a nust b	Funeral Director	205 Winter Born Lane, Apt. 4	2]	L804		USA	
036	ge I and 2 should be filed within 12 hours after death with the Maryland it of Health and Mental Hygiene. A feet file may 13 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	. 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	within 72 hour giene. ner than "natu t, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of workin	ng	16b. Kind of Busines	s/Industry
1 2 2	be filed wir ental Hygic ked other ic event, tl	Be	na na 1	n a	18. Mother's Name	(First, Middle, N	n a Maiden Surname)	
ylar	Menta Menta narked natic ev	은	Donte Demar Collins		Yoland	a Shris	es Carter	
Mar	z should Ith and Me 27 is mar r traumati		19a. Informant's Name/Relationship (Type, Print) Yolanda S. Carter/mother	19b. Mailing Address (Street a				
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition 20b. Pla	ace of Disposition (Name of emetery, crematory or other place	D	ate	20c. Location - City o	
ţ <u>i</u>	nt. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify) Sali	sbury Cremator	y 8/16	/2012	Salisbury	, MD
Ва	Depar Impo any ir		Six at the funeral Service Licensee	22. Name and Address Holloway	Funeral Ho	ome Proj	fessional	Association
D			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
	hysician/ Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence)	ence of):	rity			
	- 44	iner	Sequentially list conditions, b. Due to for its a consequent	ence off:				
CITTED	and -transit	xam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a conseque	once off:				
60 Ite be ex	ohysician and the burial-transit	dical Examiner	d d	side oi).				
3876 History	ing phys e as the	/Med	IF FEMALE:				197	
P.O. Box 68760 that the death certificate be executed	the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	death 3 L Ectopic pregnanc	зу		23d. Date of de Month	elivery Day Year
ds, P.O	been signed by the a	ا ۾ا	Part II. Other significant conditions contributing to death but not resul	lting in the underlying cause giv	ven in Part I.		pacco use contribute t	o the cause of death?
Division of Vital Records, all or Attending Physician: The law requires	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Completed				24a. Was ar autops perforr 1 \(\sum \) Yes 2	y prior to ned? death?	utopsy findings available completion of cause of es 2 M No
ician:	certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Invariant 2 F	Othe	ace of Death (Check o			
	er this neral d	te: To	27. Manner of Death 28a. Date of injury 2	28b. Time of 28c. Injury	4 U Nursing Hom at 28		nce 6 Other (Spe w injury occurred	oify)
ion	leath. tor: Aft the fur	Certificate:	2 Accident Investigation		? Yes 2 □ No			
Divis	irs after or all Direct led in by		4 Homicide determined 28e. Place of Injury - At hombuilding, etc. (Specify)	ne, farm, street, factory, office	21	8f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
he Hospi	iin 24 hou he Funei ipletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a 3 Certifying Nurse Practitioner: To the best of my	and/or investigation, in my opinio	n, death occurred at the	he time, date and	d place, and due to the	cause(s) and manner stated.
Tot	To t		29b. Signature and title of certifier	29c, License	number	2	9d. Date signed (Mon)	
			30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print) 223 Phillip	Morris	06 34	CISBURY M	00 21804
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrary Signatural AUG 1 6 2012	raile	.,	. 0/4	crowing 1.	21007
	Registra	ir	HUG I O ZUIZ CEROON 1. 17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ Timia Nikila Collins 21155 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSULA REGIONAL MODICAL. 304/364/0 HICOMICO Social Security Number 6. Sex Year If Under 7. Age (In vrs. last birthday) 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 1 □ M 2 🔀 F 08-13-2012 28 Maryland Usual Residence of Deced 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r ò 10g. Citizen of What Country? Funeral 205 Winter Born Lane, Apt. 4 21804 USA death items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces Black, White, etc 0 þ 1 X Never Married 2 Married ye 1 and 2 should be filed within 72 hours after, it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or ☐ Yes 2 🗶 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 Widowed 4 Divorced Specify Completed Black Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) aith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) nla n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donte Demar Collins Yolanda Shrises Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda S. Carter/Mother 205 Winter born Lane, Apt. 4, Salisbury, MD 21804 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, Department of Important: If any injury or one. 0 Salisbury Crematory 8/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD . Sign ture of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 land 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of use as the burial-trai Due to (or as a consequence of) iding physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) ____ JO. in the past 12 months? Year Month Day signed by the at Id be detached for Pregnant at time of death Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š should be Division of Vital Records, 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? performed' 24 hours after death.

Funeral Director: After this certificate 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be 1 Tes 2 🗶 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only bne 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1700289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILLIP MORRIS DR. A. EVANS M.D

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2012

Certificate of Death

	Physici /Medic Examir	al
eath with the Maryland	Paragraphic and a state of a stat	eral Director

1 - State

y 4		Decedent's Nam	ne (First, Midd	fle, Last)								2. Date of De		av	Year	3. Time of	Death
Physici /Medic		EVELYN	CUNNIN	NGHAM								JULY	28	-,	2012	0648	М
Examir		4a. Facility Name (If not institution	on, give street and n	umber)			4b. City,	Town, or	Location of	of Death		4	c. County	of Death		
		FT. WASH	INGTON	HEALTH &	REHA	B CENTE	:R	FT.	WASH	INGTO	N		I	PRINC	E GE	ORGE'S	
Funeral		5. Social Security	Number	6. Sex	7. Age	(In yrs. last birt		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Yea	r)	9. Birthp	place (State of	r Foreigr
Director		577-64-75	560	1 □ M 2X F		88	rs.					6-28-				I	DC
ס		Usual Residence of															
ylan Now		10a. State	10b. Count	у		10c. City, Town	or Lo	cation							1	0d. Inside Cit	
r 28e-f ahow	Director	MD	PG			FORT WA	SHI	INGTO	N							1 X Yes	2 🗌 No
286 1286	rec	10e. Street and Nu	ımber				10f. Zip Code					10g. C	Citizen of V	Vhat Cour	ntry?		
章 0 元		10010 WI	ESTERLY	LANE			20744				US						
	Funeral	11. Marital Status	Armed Forces? 1 Never Married 2 Married 1 Yes Am No						dent of H cify Cuba 2 X No	ispanic Ori in, Mexicar Specify:	n, Puerto	ecify Yes or No Rican, etc.)	D-		k, White,	can Indian, etc.	
ours	by	3 XWidowed	3 XWidowed 4 Divorced Year or Dates:											Specify	ВПС		
72 h	etec	(Spe	15. Decedent's Education (Specify only highest grade completed)						16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)				16b.	Kind of Bu	ısiness/In	dustry	
2 should be filed within 72 hours atter and Mental Hygiene Is marked other than "natural, or its aumatic avant, the Modical Examina	ompleted	Elementary/Sec 12TH	ondary (0-12)	College	(1-4or 5+			1AKER	se retired	1)		PRIVATE					
be filed wit tal Hygien d othar th avant, the	O	17. Father's Name	(First, Middle	, Last)						18. Mothe	er's Nam	e (First, Middle	, Maide	e <i>n Sum</i> am	10)		
id be ental kad c	To B	JAMES MA	ARSHALI							CATH	ERIN	E DORSI	ΕY				
d 2 should th and Mer 7 is marks traumatic	-	19a. Informant's N	lame/Relation	ship (Type, Print)		19b.	Mailir	ng Address	(Street	and Numb	er or Rur	al Route Numb	er, City	y or Town,	State, Zip	Code)	
1 and 2 Health a am 27 is ther trai		DEBORAH	A. LEW	IS/DAUGHT	'ER	10	010) WES	TERL	Y I.AN	Е. Б	T. WASI	HTNC	TON.	MD 2	20744	
s 1 and 3 f Health item 27 other tr		20a. Method of Dis	sposition			20b. Place of	Dispo	sition (Name	me of			Date	20c.	Location -	City or To	own, State	
permit. Pages Department of I Important: If its any injury or o'		1X Burial 2 4 □Donation		3 □Removal from (Specify)	n State	LINCOL	N C	CEMET	ERY	8	-4-2			JITLA			
mit.		21. Signature of F	uneral Servic	e Licensee			22	2. Name ar	nd Addre	ss of Facili	ty POP	E FUNE	RAL	HOME	S, P.	Α.	
8 5 E 8	1	1	1/1/1	1/4.0	M	MOST	5	5538	MARL	BORO	PIKE	, FORES	STVI	LLE.	MD 2	20747	

Physician /Medical Examiner

The law requires that the death certificate be executed

detached

cate has been signed by page 2 should be detact

certificate

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

6:Jm

DHMH 17 Rev 1/2001

To the Hospital or Attanding Physician:

Completed by

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-tran

HYPERTENSIVE	HEART	DISEASE
Due to (or as a consequen		

Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of)

MALIGNANT NEOPLASM OF BREAST

DIABETES MELLITUS/DEMENTIA

Physician/Medical IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

HYPERCHOLESTEROL

25. Was case referred to medical examiner?

1 ☐ Yes 2X No

27. Manner of Death 1X Natural

2 Accident

3 Suicide

4 Homicide

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Qnknown

24a. Was an 2**X** No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA 2 X ER/Outpatient 28b. Time of

R182162

28d. Describe how injury occurred

28a. Date of Injury (Morith, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

5538 MARLBORO PIKE, FORESTVILLE, MD 20747

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARSAL BROWN, DNP, FNP-BC 11711 LIVINGSTON RD, FT. WASH., MD 20744

State Registrar 31. Date filed (Month, Day, Year) AUG 1 3 201 3. Registrar's Signature

			for State Registrar	State of Mar		artment of r rtificate of L			giene — • Reg. No.	
П			Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	3. Time of Death
н	Physicia Media		Maria del Carmen					08/14	$/20\overset{\text{Day}}{1}2$	3:00 p M
Acres	Examir		4a. Facility Name (if not institution, give stre	et and number)			Location of Death	1	4c. County of	
April 10			3208 Toledo Pl			Hyatts		T		e George
	Funeral Director		5. Social Security Number 214-63-0129 Usual Residence of Decedent		o yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)		B. Birthplace (State or Foreign Country) Panama
	and show dat	ē	10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f otifie	Director	Md Prince	George	Hyatts	ville				1 XYes 2 No
	a or		10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th wit ms 23 must	Funeral	3208 Toledo Pl			20782			U.S.A.	
Strain Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md Prince George Hyattsville 10c. Zip Code 3208 Toledo Pl 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1										American Indian, White, etc. Hispanic
5-("nat "nat	ble	15. Decedent's Educa (Specify only highest grade		(Give i	kind of work done o	ation during most of wor	king	16b. Kind of Busin	ness/Industry
121	within 72 ygiene. her than '	No.	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	life. D	O NOT use retired)			77 . 4 . 3	
d 2	filed will Hygid al Hygid	Be (17. Father's Name (First, Middle, Last)		nou	sekeeper	18. Mother's Nar	ne (First, Middle, I	Hotel Maiden Surname)	
/lan	should be fill and Mental is marked or aumatic eve	오	Percival Hudson					Grant G	,	
	d 2 should alth and Me 27 is marler traumati		19a. Informant's Name/Relationship (<i>Type</i> , Karla Carter/Daugh						City or Town, State	
Baltimore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place		Date / 23/12	20c. Location - Cit	
alti	permit. For Department of the poorts and injury once.		21 gnat of Funeral Servi Licensee	1000						eral Home
<u> </u>	9 9 E 6 9		Kennenuls	es s					on D.C. 2	20017
	h sician/		3a. Part 1. Enter the disease or complica shock, or heart failure. List only one c Immediate Cause (Final disease or condition	tions that caused the ause on each line.	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est, NCEA-	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co			ONe year			
	per (Ta	miner	Sequentially list conditions, b. and any leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to (under a co	r sequence of y					
	tificate be executed ng physician and as the buriter and	I Exa	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of):	· · · · · · · · · · · · · · · · · · ·				
09	ate be physici the bu	dice	d.,							
Box 68760	e death certific the attending r hed for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date o Month	of delivery Day Year
P.O.	hat the ed by detac	by Ph	Part II. Other significant conditions contri	outing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribu	te to the cause of death?
ls, l	uires t n sign uld be	ed b						1 🗆 Y	es 2 X No 3[☐ Probably 4 ☐ Unknown
Ö	w required to specifications and specifications are specifications.	Completed						24a. Was a	n 24b. Wer	e autopsy findings available
Rec	The la ate ha page	lo m						autops perfori 1 Yes	med? deat	r to completion of cause of th? Yes 2 \(\sumbedge\) No
<u>a</u>	sian: ertifica ector,		25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec		2010	1705 2 2 2 170
Ξ	Physician: The lav r this certificate has aral director, page 2	잍	1 Yes 2 X No	1 🗆 Inpatient	2 ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursing H	ome_5 X Reside	ence 6 🗆 Other (S	Specify)
Division of Vital Records,	nding P th. : After t e funera	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye	ar) 28b. Time of injury	28c. Injury work M 1		28d. Describe ho	w injury occurred	
N N	the ear		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e Place of Injury -				28f. Location (St.	reet and Number o	- Divini Davida Ativachasi
	ital or Attending Phy urs after death. ral Director: After this lled in by the funeral o			building, etc. (S)	pecify)	eet, factory, office		City or Town		
Δ	the Hospital or Atter nin 24 hours after dea the Funeral Director npletely filled in by th	Medical	29a. Certifier (Check only one) 1 Acertifying Physicia 2 Medical Examiner: 3 Certifying Nurse Properties (Check only one) 2 Certifying Nurse Properties (Check only one) 3 Certifying Nurse Properties (Check only one) 2 Certifying Nurse Properties (Check only one) 3 Certifying Nurse Properties (Check only one) 3 Certifying Nurse Properties (Check only one) 3 Certifying Nurse Properties (Check only one) 4 Certifying Physicia (Check o	building, etc. (S) n: To the best of my On the basis of exam	pecify) knowledge, death of ination and/or invest	occurred at the time	n, death occurred a	City or Town and due to the cau t the time, date an	use(s) and manner a d place, and due to	as stated. the cause(s) and manner stated.
٥	To the Hospitt within 24 hours To the Funera completely fille	Medical	29a. Certifier (Check 2 Medical Examiner:	building, etc. (S) n: To the best of my On the basis of exam	necify) knowledge, death of ination and/or invest at of my knowledge,	occurred at the time igation, in my opinio death occurred at the 29c. License	n, death occurred a ne time, date and p number	City or Town and due to the cau t the time, date an ace, and due to the	use(s) and manner a d place, and due to e cause(s) and mann 19d. Date signed (M	as stated. the cause(s) and manner stated. ner as stated. fonth, Day, Year)
	To the Hospital or Atter within 24 hours after dea To the Funeral Director Completely filled in by the	Medical	29a. Certifier (Check only one) 3 Certifying Physicia Certifying Nurse Program (Check only one) 3 Certifying Nurse Program (Check only one) 3 Certifying Nurse Program (Check only one) 30. Name and address of person who compared to the com	building, etc. (S) n: To the best of my On the basis of exam actitioner: To the be	necify) knowledge, death of ination and/or invest at of my knowledge,	occurred at the time igation, in my opinio death occurred at the 29c. License	n, death occurred a ne time, date and p number	City or Town and due to the cau t the time, date an ace, and due to the	use(s) and manner a d place, and due to e cause(s) and mann 19d. Date signed (M	as stated. the cause(s) and manner stated. ner as stated.

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		For State		State	of Maryl				d Mental H	ygiene	201	2	2823
		Registrar	(F) 1.45'11'	(4)		Ce	rtificate of	Death		Reg. No.	201		2023
Physicia	in/	1. Decedent's Name	e (FITST, IVIIdal e ,	,					2. Date of D Month		, a X	ear _	3. Time of Death
Medic		4a. Facility Name (if	not institution	ANNA		HERINE	DAV]		Augus			12	2:30 A ^M
Examir	ier				,	:+-1		or Location of De erick	eath	4c.	County of Fred		ale
Funeral		5. Social Security Nu	umber (morial 5. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yea	If Under 24 F		l lirth	9	. Birthpla	ace (State or Foreign
Director		213-24-		1 M 2 □ F	87	Yrs.	Months Days	Hours M	in. 06/26	7192	_	Country SA	<i>()</i>
nd now	Ļ	Usual Residence of 10a. State	10b. County		100	City, Town or Lo	cation	l				100	d. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD	Frede	erick		eymar	cation					100	1 Yes 2 No
the N	<u> </u>	10e. Street and Num	nber				10f. Zip Code			10g. Citi	zen of Wha	at Country	
s 23a	era	12446 R	enner	Road			21757			U.	S.A.		
death item ner n	F.	11. Marital Status		12. Was Dece Armed Fo	edent Ever in	U.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Origin? Dan, Mexican, Pu	(Specify Yes or No)- 1	14. Race -		
after II", or xami	d by	1 Never Marri		If Yes, Giv	rces? 2 X No		I ☐ Yes 2. N		0.10 (1.0041), 0.10.1,		Black, Specify: W	White, etc hit e	
atura cal E	etec	3 🗆 Widowed 2	15. Decedent	Year or Da	ates.	16a Dono	dent's Usual Occu	notion					
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shound n and 7 is m		19a. Informant's Nai	me/Relationship	o (Type, Print)	ahta	19b. Mailir	ng Address (Stree	t and Number or	Rural Route Numb	er, City or T	Town, State	e, Zip Coo	de)
and 2 Health em 2 ; ther t		20a. Method of Disp		anduat				wood D.	rive Yu				Y == 1
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perm Deps Impo any i		21. Signature of Fun	leral Service Lic	Back		4	Name and Addr 522 But	ess of Facility Cler St	Alessa Pitts	ndro burg	Fun h F	eral	5261 ^{me}
	Н	23a. Part 1. Enter th	ne disease, or c	omplications that of	aused the de							1	pproximate
Physician/		shock, or hear Immediate Cause (F	t failure. List on Final	ly one cause on ea	ch line.	1		1		,		Ir	nterval Between Onset and Death
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Examiner	_					, ,							
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cuted nd transi	каш	Cause (Disease or injury that initiated events c.											
be executed sician and burial-transi	cal E	resulting in death) L	ast	Due to	or as a cons	equence of):							
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requires that the death certificate been signed by the attending phy should be detached for use as the		IF FEMALE:		23c. If yes, out	come of pred	nanov							
ath ce attend for us	cian	23b. Was decedent p in the past 12 m	nonths?	1 🔲 Live	Birth 2 F nant at time	etal death 3	Ectopic pregnar Other (specify)	су		2	3d. Date o Month	f delivery Da	ay Year
y the	ysi	1 Yes 2 2 9 Unknown	l No	9 Unkr		ordeath 5 L	Other (apecity) _						
that the property of the prope		Part II. Other signific					nderlying cause g	iven in Part I.	23e. Did	tobacco us	e contribu	te to the o	cause of death?
urres n sigr	Completed by	E'nd S	stage	- Dem	enti	à			_ 1 □	Yes 2] No 3[Probab	oly 4 Unknown
v req	jet								24a. Was	s an	24b. Wer	e autopsy	/ findings available
he lay te hay	E O								perl	opsy ormed?	deat	h?	eletion of cause of
an: I		25. Was case referred	d to medical				26. F	Place of Death (C/		2 🐼 No	1 🗆	Yes 2	∐ No
nysici lis ce	10	examiner? 1 Yes 2	No	Hospital: 1 🗹	Inpatient 2	☐ ER/Outpatien	t 3 🗆 DOA Ott	ner: 4 \(\sum \) Nursing	Home 5 Res	idence 6	Other (S	pecify)	
ng Pr		27. Manner of Death	5 Pending	28a. Date		28b. Time of	28c. Inju	y at	28d. Describe			, , , , ,	
tendi leath. tor: A the fu	ifica	2 Accident 3 Suicide	Investigat	t be			M 1 🗆	Yes 2 ☐ No					
or At after of Direct in by	Certificate:	4 Homicide	determine	28e. Place	of Injury - At ng, etc. <i>(Sp</i> ec	home, farm, stre	et, factory, office		28f. Location City or To	Street and wn, State)	Number or	Rural Ro	oute Number,
Thospiral or Artending Prystotan: The law requires that the death certificate At hours after death. Funeral Director: After this certificate has been signed by the attending phy stely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1	Certificing	hyeinian: To tha b	act of multi-	wolodes d*	coursed at the 1	o data and 1	and distant		d r		
to the hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2 secompletely filled in by the funeral director, page 2 secompletely filled in by the funeral director.	Medical	(Check 2 L	Medical Exa	hysician: To the baniner: On the bas uriner: On the bas urse Practitioner:	is of examina	tion and/or invest	gation in my onin	on death occurre	d at the time date	and place a	and due to	the cause	(s) and manner state
vithin To the comple	— r	29b. Signature and tir	tle of certifies				29c. Licens		piace, and due to		signed (M		
		Dia	reki	udert	f CR	no	R11	5108			121		
	L	- + - +	V 1				4/11						

State Registrar

O-WC

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

CRNP 516 Trail Avenue Frederick, MD
32. Registrar's Signature

39 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diane Ruckert CRNP 516 Tr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gilda DeMarco 2012 Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Worcester Berlin Nursing Home Social Security Number 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. Country) **Director** 100-05-9100 100 NYUsual Residence of Decedent 28a-f show il Hygiene. I other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9715 Healthway Dr. 21811 USA and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Demarco, Gilda altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3℃ Widowed 4 □ Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Frank Guagliardi Maria Giuseppe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Robin Dean Dailey / friend 10439 Assateaque Rd., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a
Department of I 1 ☐ Burial 2 XCremation 3 ☐ Removal from State any injury once, State Crem. 8/17/2012 Millsboro, DE 4 Donation 5 📮 First 21. Signature of Fund 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter th disease, or complications tal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or hear failure. List only one cause or Immediate Cause (Final Onset and Death Physician/ tailure to disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Olestrichi burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last homic Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2**X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at or Attending Parter death.

Director: After t 28d. Describe how injury occurred X Natural 5 Pending injury ☐ Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, August 15, 2012 R 131285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

211

DHMH 17 Rev 7/2009

State

Registrar

Mary Bernak-Clark,

AUG 17

31. Date filed (Month, Day, Year)

9715 Healthway Dr, Berlin, MD

21811

FNP-BC,

			Please	e Type or Pr						-		-	jible.	
		For State		State of M	/larylan	-	artment of I rtificate of L		and N		_	21) [2	2 28233
		Registrar 1. Decedent's Nam	e (First, Middle, La	ast)		007	tinicate of t	Joann		2. Date of De	Reg. N ath	0.		3. Time of Death
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Exami	ner		11100	re street and number) Ty Hospita	1		4b. City, Town, or Lank		of Death	,		c. County Princ		eorge's
Funeral Director		5. Social Security N 219–58–9	9742 6.5		ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 08/04/	th y, Year)		9. Birt	hplace (State or Foreign untry)
and show Lat		Usual Residence	of Decedent 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Maryli 28a-f	Director	Md.		G.	Se	eat Pl	easant						_	1 🏿 Yes 2 □ No
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be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 🔀 Never Marr 3 □ Widowed	ried 2 Married	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give	?	'	Was Decedent of H If Yes, specify Cuba			ecify Yes or No- Rican, etc.)		Blac	e - Americk, White	
n 72 hours e. an "natura Medical E	Completed	(Spe	15. Decedent's ecify only highest g		5.1)	(Give	dent's Usual Occup kind of work done o O NOT use retired)		t of worki	ng ý		Kind of B	usiness/	
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2 should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	10 E	17. Father's Name (- James [e (First, Middle, enevieve			,	
1 and 2 should be f Health and Men item 27 is marke other traumatic			Deal/Dau				ng Address (Street & Suiter V						State, Zip 2078:	
permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:				Removal from State	e Ce	emetery, cren	osition (Name of matory or other place Iem。 Park		80\80	Date B / 1 2				Town, State aryland
permit. F Departm Importa any injui		21. Signature of Fu		isee)						1	_			o.C. 20019
Physician/		23a. Part 1. Enter t shock, or heal Immediate Cause (disease or condition	rt failure. List only Final	nplications that cause one cause on each lir	cd the death							nngt	on,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	ſ	a. Due to (or as	a consequ	ence of):	idne	4 6	-Ai	NUV.	و			
ted nsit	Examiner	Sequentially list co il any list con cause. Enter Under Cause (Disease or	rlying injury	b. Due to (ar as	B GURRIUD B	onco offi								
oe executed ician and burial-transit		that initiated events resulting in death) I	s I	Due to (or as	<u> , , , , , , , , , , , , , , , , , , ,</u>		المان و	e 46	رر	14.1				
ficate by physical ph	Medic			d							_			
Attending Physician: The law requires that the death certificate be st death. St death. St death. By the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? No	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	у				23d. Da Mo	te of deli	very Day Year
uires that the signed by	þ	Part II. Other signif	icant conditions	contributing to death	but not resu	ulting in the u	inderlying cause giv	en in Part	1.					the cause of death?
The law rec cate has bee	Completed									24a. Was a autop perfo	ssy rmed?		orior to d death?	opsy findings available ompletion of cause of
sician: The certificate lirector, pag	o Be	25. Was case referre examiner? 1 \sum Yes 2		Hospital:			Othe	ace of Dear						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certificate: To	27. Manner of Death 1 X Natural 2 Accident	<u> </u>	28a. Date of inju (Month, Da	ury :	=R/Outpatier 28b. Time of injury	28c. Injury	4	2	me 5 Resid 28d. Describe h				fy)
al or Atte s after de al Directo ed in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj	ury - At hor c. (Specify)	ne, farm, stre	eet, factory, office			28f. Location (S City or Tow			er or Run	al Route Number,
he Hospit in 24 hour he Funera	Medical	(Check 2		vsician: To the best of the basis of the bas	examination	and/or invest	tigation, in my opinic	n, death oc	ccurred at	the time, date a	nd place	e, and due	to the c	ause(s) and manner stated.
To t with To t		29b. Signature and	•	Andello	·,	9	29c. License		39		29d. Da	ate signed	i (Month	Day, Year)
			ess of person who	completed cause of a				ωa,	-kapa	olis Rd,	Suit	0229	, Glen	41 Dale, my, 2569
Sta Registr	te ar	31. Date filed (Mont)	n, Day, Year) 2012		ar's Signatu					,				

0400	Type of Time in Die	ack machbic mik	LIIOUIC AII	oopies Ale
	State of Maryland /	Department of He	alth and Ma	ntal Hygiene

evin James Dar	-	1- For State Registrar	S	tate of Maryla	and / I		ment of H <i>icate of D</i>		nd Men	ntal Hygi		Reg. No	201	2 2823
Physicia Medical Examin	n/	Decedent's Name								N	Date of Dea	ath Day	Year	3. Time of Death
viedicai ⊏xainin	er	KEVIN J		DARBY on, give street and no	umber)		4b. (City, Town, c	or Location		ugust 13	3, 201	c. County of Dea	1608 hrs
		7758 Marlbo		, 3	,			orestville					Prince Georg	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs, last l	-	Under 1 Ye			Date of Bi	irth (MN	M/DD/YYYY) 9. B Fore	irthplace (State or
Director		579-90-0		1 X M 2 F	<u> </u>	52	Yrs.	nontris Da	ys	S WIIII.	07/1	3/1		ountry) DC
any	ŀ	Usual Residence of 10a. State	Decedent 10b. County		10	c. City, Tov	wn or Location							10d. Inside City Limits
Maryland 28a-f show	۱	MD	PRINC	CE GEORGE'	S	TEM	PLE HIL	LS						1 X Yes 2 No
Maryla	Director	10e. Street and Nur	mber		<u> </u>		10	f. Zip Code			1	10g. Ci	tizen of What Co	untry?
with the Maryland ms 23a or 28a-f sho be notified at once		4623 DAL	LAS PI		. d. 75		140.391	20748		10/0			TED STA	
0036 within 72 hours after death with the Maryland jiene. ier than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Funeral	Never Marrie	ed 2 X M	12. Was Dec Armed F 1 Yes						gin? (Specify n, Puerto Rica		0-	White, etc.	rican Indian, Black,
after d		3 Widowed	4 Div	vorced If Yes, Give Yes		NO	1 Ye	s 2 X N	o specify:	•			Specify: BLA	CK
5036 within 72 hours after in a "natural", Medical Examiner	Completed by	15. Decedent's Ed		ecify only highest gra			a. Decedent's L during most o				done	16b.	Kind of Business	/Industry
36 hin 72 e. than	9	12th	ondary (0-12)	College (1-4 or 5+)		Solf	Emp	Joue	d			PRIVATE	<u>.</u>
5-00 led wit Lygien uther		17. Father's Name ((First, Middle	, Last)		<u> </u>	341	- 1		r's Name (Firs	st, Middle,	Maider		_
21215-0036 Jud be filed within 7 Mental Hygiene I marked other than it event, the Medical	Be	JAMES OS								RNICE I				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	٩	19a. Informant's Na KEONIA A											City or Town, Stat ILLS, MD	
ore, MD ;		20a. Method of Disp	osition				e of Disposition	(Name of ce		Da			Location - City o	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr		4 Donation 5		n 3 Removal fr	om State	RIVE	RDALE F CREMAT			8/17	/20/2	2 RI	VERDALE	• MD
Baltimo permit. Page Department of Important:	1	21. Signature of Fur			noo	981	22. Name	and Addres	s of Facility	POPE	FUNEF	RAL	HOMES,	P.A.
Physician	+	Charles 23a, Part I. Enter the		Complications that	ed the	death. Do	not enter the m	8 MAR	LBORO	PIKE,	FORE	ESTV	VILLE, M	D 20747 Approximate Interval
/Medical		failure. List onl Immediate Cause (i	y one cause	on each line.	/			, ,	,		,	,	,	Between Onset and Death
Examiner		or condition resultin		Due to (or as a				-						
	ē	Sequentially list cor if any, leading to im		b. Due to (or as a	consequ	ence of):								
	티	cause. Enter Under (Disease or injury th	nat initiated	c. Due to (or as a	consequ	ence of):								
outed nd ransit	Ĕ	events resulting in o	death) Last	d.	consequ	ence or).								
60, tre be executed systician and burial - transit	edical	UNPENDED		AMENDED										
8760, ificate be g physic s the bun		IF FEMALE: 23b. Was decedent p		23c. If yes,		of pregnanc	y 2 Fetal de	eath 3	Ectopic	c pregnancy		23	d. Date of deliver	y Day Year
Box 687(e death certifica the attending ple ed for use as the	2 2 2 3	past 12 months		4 Pregn	ant at tim	e of death		(Specify)		- Frogracio			11101101	Day Tour
D.O. Box 6876 that the death certificat ted by the attending ph detached for use as the	Physician/N			tions contributing to		ut not result	ing in the under	lving cause	given in Pa	art I	23e Did to	obacco	use contribute to	the cause of death?
P.O. es that the igned by	2						ing in the direct	iying sadoo	9.70.71.71					bably 4 Unknown
of Vital Records, ig Physician: The law require there will certificate has been si neral director, page 2 should	Completed										24a, Was autop			utopsy findings available completion of cause of
tal Reco	틹											rmed?	death?	
ician: 1	8	25. Was case referre	ed to medica	Hospital:				26.Place		(Check only o	one)			
Physic Physic real direction	악	1 ✓ Yes 2 27. Manner of Death		,	npatient	_	Outpatient 3	DOA 28c Init	Other ₄	Nursing Hor			ence 6 🗸 Othe	r: Scene
on of ending Pl ath. r: After he funera		1 Natural	5 Pend				OUND:		Yes 2 🗸	Sub	ject sho			
Division tal or Attendi rs after death. al Director: A led in by the fi	Certification:	2		stigation Aug 13, 28e. Place			41 hrs farm, street, fa	ctory, office b	building, etc	c. 28f.				ural Route Number, City
		4 Homicide				(specify							, Forestville, M	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	100	(Check only		hysician: To the bes miner:On the basis of	of examina							, ,		
To wit	Ě	29b. Signature and t	title of certifie	and manner si	tated.			29c. Licens	se number			29d.	Date signed (Mo	nth, Day, Year)
		Card	e H	alla	v			O.C.	M.E.			Aug	gust 14, 2012	
25m		30. Name and addre Carol H. Alla		who completed caus Assistant Medic			•	more Str	et Balti	imore MD	21223			
Stat	e	31. Date filed (Mont	Day, Year)		gistrar's S				JCI, Daill	IIIIOIE, IVID	21223			
Registra		AU	2 4 1	CAIR LAND	wa	A.	parke							
DHMH 17 Rev 1/200	1			OCME		0	RIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28235 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 15, Golden L. Enriquez 2012 4:30 a M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Min Days 138-50-3164 **Director** 1 🗆 M 2 🔀 F 58 May 11, 1954 Ohio 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director or 28a-f s notified 1 Yes 2 No MD Montgomery Takoma Park ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7720 Maple Avenue 20912 USA ral", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: Black 1 ☐ Yes 2 K No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever မ Golden Brown Collins Doris Esther Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13917 Castle Blvd., Apt. 22, Silver Spring, MD 20904 Jessica Nichols/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ₹ ± 5 1 Burial 2 Cremation 3 Removal from State George Washington Aug. 21, Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD Cemetery Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final PANCREATIC CANCER Physician/ unknown disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Exami I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and 2 Due to (or as a consequence of) resulting in death) Last Physician/Medical the but Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 Month Day Year 1 Yes 2 Pregnant at time of death been signed by the a should be detached f Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anema 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No I Natient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🔲 Yes 1 Natural 5 Pending filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a of certifie 29d. Date signed (Month, Day, Year) August 15, 2012 D61007 10 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) 12520 PROSPERITY DR #320 SILVER SPRING, MD ZO904 KENNETH KHANDAGLE

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month

Year,

1 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 28236 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 8-04-2012 Physician/ 6:46 P M EARNEST EDWARD EUBANKS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PG SOUTHERN MARYLAND HOSPITAL CLINTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Mir Director 577-50-4960 1 X M 2 □ F 10-01-1934 WVA 78 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No MD PG TEMPLE HILLS 0. 10e. Street and Number 10g. Citizen of What Country? Funeral 3420 RICKEY AVE. #253 20748 UNITED STATES 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces? 1

Yes 2

No 1 Never Married 2 X Married and 2 should be filed within 72 hours after ا Health and Mental Hvriens ģ 1 ☐ Yes 2 X No Specify. Specify: BLACK Year or Dates 1954-1956 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) ROUTER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JESSE EUBANKS SALLY HENRI MCGRAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac 3420 RICKEY AVE., #253, TEMPLE HILLS, MD 20748 THELMA EUBANKS/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ARLINGTON NATIONAL CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-18-2012 ARLINGTON, VA 21. Signa ure Funeral Service Lice 22. Name and Address of Facility POPE FUNERAL HOME, P.A. arri 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ARTHEROSCLEROTIC CORONARY ARTERY DISEASE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Physician/

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

3 In State

29b. Signature and title of certifier

a 0

ERIC MCDONALD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Completed by Physician/Medical Exam	Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):			
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown	23c. If yes, outcome of pregn. 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌 Ectopi			23d. Date of delivery Month Day Year
ted by Pi	Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlying	g cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Comple					24a. Was an autopsy performed? 1 □ Yes 2	
Be	25. Was case referred to medical examiner?			26. Place of Death (Ch	eck only one)	
ျှ	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆	DOA Other: 4 Nursing	Home 5 Residence	6 Other (Specify)
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inju	ury occurred
Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)
Medica	(Check 2 Medical Examin	sician: To the best of my know iner: On the basis of examination se Practitioner: To the best of	on and/or investigation, i	in my opinion, death occurre	d at the time, date and place	ce, and due to the cause(s) and manner stated

29c. License number

D0064055

08/09/12

DHMH 17 Rev 06-2011

Registrar

7503 SURRATTS ROAD, CLINTON, MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 13° 2012° 1718 Dwayne Nathaniel Everett Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Days Hours (Month, Day, Year) **Director** 213-88-8050 1 X M 2 F 48 Jan. 5, 1964 Usual Residence of Decedent Maryland or 28a-f show e notified at 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Prince George's Laurel 1X Yes 2 ☐ No Maryland 23a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with must 11533 Laurelwalk Drive 20708 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Force "natural", or i Yes 2 No Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th other 1 Landscape Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever ပ္ Maurice Everett Sandra Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other train Sandra Everett - Mother 11533 Laurelwalk Drive Laurel, Maryland Date 21, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery crematory or other place)
Mary Land
National Cemetery Department Important: It any injury or August 4 Donation 5 Other (Specify) 2012 Laurel, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewar M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 25 Cay S Immediate Cause (Final Physician/ disease or condition resulting in death) Spinal Cord Injury Medical Due to (or as a consequence of) Examiner Anoxic Brain Injury days Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine AL EXAMIN 25 days Cause (Disease or injury that initiated events resulting in death) Last Fall CONTINUENTON APPROVED BY MON as the burial-tran Due to (or as a consequence of): ding physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year 9 🗍 Unknown 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes Hospital 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending XAccident 1 X Yes 2 □ No Fall from a Tree Investigation 7:56 A M 7/19/12 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) 4426 Ockford Lane Bowie, Md. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 201 ess of son who completed cause of death (Item 23a) (Type, Print) Taten Wandji 22 S. Green Street 21201 Baltimore, Maryland Marce1

State

Registrar

32. Registra

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month of largare 2012 34 Medical 4a. Facility Name of not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs
Manths Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 579 40 1251 Director 1 □ M 2 🔏 F 80 Yrs Dec 1, 1931 Maryland Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Prince George's Clinton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 7812 Glendinnen Drive 20735 er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Yes . 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Hame Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ျှ James F. Stone Estelle L. Sutard 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other transcents. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7812 Glendinnen Drive, Clinton, MD 20735 Donald Quinn (grandson) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Aug 22, 2012 Cheltenham, MD Signature of Funeral Service Lice 22. Name and Address of Facility Lee Funeral Hone, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Lutra cerebral Hemarrhage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 15 40415 Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Anticoagulatur attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Description of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Intra cerebral Previous hemovihage Division of Vital Records, 1 Yes 2 No 3 Probably Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 24a. Was an autopsy performed? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatura and title of certifier 00051482 down address of person who completed cause of death (Item 23a) (Type, Print) M. GONIN 2001 medical Parhway 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle | ast) 2. Date of Death Physician/ Month Reginald 0340 AM C. Foster 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Director 230-88-1975 1 🖾 M 2 🗆 F 55 3-25-57 Virginia Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lary or other traumatic event, the Medical Examiner must be notified at Jury or other traumatic event, the Medical Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8604 Captain House Rd 20603 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. 2 No 1974 þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced Specify: Black 1982 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Asst. Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Foster John Κ. Foster Zeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Angela Foster / Wife</u> 8604 Captain House Rd, Waldorf MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 8-21-12 Cheltenham, o Funeral Se ce Ligens e 22. Name and Address of Facility 21. Signaty Adams Funeral Home Pa, aquasco Md 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sici. n disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death in the past 12 months? for Month Year Pregnant at time of death 5 Other (specify) Day signed by the a 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ehydration Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 \(\subseteq \) No 24a. Was an performed? certificate Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🕱 No Other: 1 Yes ္ဝ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deau..

To the Funeral Director: After th

"manietely filled in by the funeral" funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certil 29d. Date signed (Month, Day, Year) 00618 08-13-12 mpleted cause of death (Item 23a) (Type, Print) 11014 Kabin 1

State Registrar 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name 2. Date of Death **Physician** Month 2012 Hugust /Medical County of Death Name (If not institution, 4b. City, Town, or Location of Death Examiner PVS If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Year) Min. 1 □ M 2 🔀 F Hours 497-10-8119 94 **Director** 12, 1918 May Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show "natural", or Items 23a or 28a-f shov sdical Examiner must be notified at MD Montgomery Director North Bethesda 1 TYes 2 TXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10500 Rockville Pike, #1512 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 is marked of any injury or other traumatic ew Golden Douglas Zike Sophia Nellie Vaughn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David G. Fischer/Son 5801 Nicholson Lane, #1710, North Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Lawn Memorial Aug. 21,
Garden 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 XRemoval from State 5 Other (Specify) 4 Donation Meridian, MS 21. Signature funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Secondary to acute 1888 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last edical Examiner Due to (or as a consequence of): sician and burial transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2⊟No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe ing 2 No 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury

The law requires that the death certificate be executed Records, P.O. Box 68760, Vital ō or Attending

with the Maryland

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

attending physician for use as the buria ed by the a n 24 hours after death.

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Physician/M
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To Be
Certification: 1
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2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of

30. Name and address

6 ☐ Could not be

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Year)

(Month, Day, Yea AUG 20

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State

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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and manner stated.

Registrar's Signature

1 ☐ Yes 2 ☐ No

5e practitioner 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

olecu

Nurse

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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ams		30. Name and address of person who com		23a)								
110			int Medical Examiner		0 W. Baltimo	ore Str	eet, Baltim	ore, MI	21223			
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Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Med Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
Funera		Chesapeake Woods Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cambridge If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea						
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ith the M	Funeral Director	10e. Street and Number 1910 Church Creek Road	10f. Zip Code 21622	10g.	. Citizen of What Cou USA	intry?				
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To the within										
2+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Patricia Johnson D.O. 100 Bramble	H005997. St., Cambridge,		0119/10					
St Regist	ate rar	31. Date filed (Month, Day Year) 7 2012 32. Registrar's Signature								

State of Monand / Department of Health and Mental Hygiene - State - Registra/AMEND#8perFH, 8/29/12HW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A Worth . 12 . 2012 Year Stewart Eugene Gay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. The Party of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **x** M 2 □ F Days Hours 39 **Director** 240-15-4258 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10a. State 10c. City, Town or Location Director MD Prince George' Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5602 16th Avenue Apt.101 20782 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfred Eugene Perry Sr. Elnora Gay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27537 Department of Health a Important: If item 27 is any injury or other tra Devone Richardson/Sister 723 Foster Road Henderson, North Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ¦8/19∲2012 Burial 2 Cremation 3 🙀 Removal from State Jesse Kittrell Cem. 4 ☐ Donation 5 ☐ Other (Specify) PHYMEPPADESRINALDI FUNERAL SERVICE, P.A. 21. Signature 9241 Columbia Blvd.Silver Spring,Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): сотрleted filled in by the funeral director, page 2 should be detached for use as the burial the attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe After this certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 02 30. Name and address of persen who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

b629

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Country) N.C.

4c. County of Death

Montgomery

USA

14. Race - American Indian Black, White, etc.

Specify: Black

Church

Kittrell, N.C.

23d. Date of delivery

death?

Day

24b. Were autopsy findings available prior to completion of cause of

Year

Month

Interval Between

Onset and Death

16b. Kind of Business Industry

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

000

TAKUMA

State of Maryland / Department of Health and Mental Hygiene 20 | 2 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ August GRAMBUN 2012 EDGAR :44A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Hospital Georges Commonity **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Min (Month, Day, Year) Director 248-36-4217 -02-1930 82 Usual Residence of Decedent mary land permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director Suitland mD Prince (zeorges 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20746 2019 Houston Street U.SA. 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Divorced 4 Divorced Specify: BIACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government tederal Security BLIN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JR Greorge Gramblin Pauline Hightower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AM Dorothy Gramblin - WIFE 2019 Houston Street Suitland, IND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date chelten ham Cemeter 08/17/2012 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Chelten ham, Mary land 4 Donation 5 Other (Specify) Signature Juneral Service Licensee 3831 Greens are Nuc LATNEY FUNERAL HOME VOSKINGTON. D.C. nter the disease, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . Part 1. Inter the disease, or complica shock, or heart failure. List only one c Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a x nsequence of) **Examiner** neumonio Sequentially list conditions Examiner it any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 sl autopsy performed? 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2- No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending Accident ours fter death eral birector A filled in by the f 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) MDD 6092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good ROAD, LANham Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 8 2 4 5

Certificate of Death

Reg. No.

			1 - State Registrar Co	ertificate of D	Death	.v.ocar r ry	Reg. No.	012	20240		
Physician/ Medical			Decedent's Name (First, Middle, Last) Ronald Geiger			2. Date of De Month	eath Day	Year 2012	3. Time of Death 04:00 A M		
	Examin		4a. Facility Name (if not institution, give street and number) 8505 Carrollton Parkway	4b. City, Town, or New Car	Location of Deat	h	4c. County of Death Prince Georges				
	Funeral Dírector		5. Social Security Number 578−52−7520 6. Sex 1 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days	If Under 24 Hrs Hours Min.		ay, Year)	Coun	place (State or Foreign htry)		
	iryland a-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	J			1	10d. Inside City Limits 1 X Yes 2 □ No		
rith the Ma 23a or 28a	vith the Me 23a or 28s st be notif	Funeral Director	Maryland Prince Georges New Ca 10e. Street and Number 8505 Carrollton Parkway	rrollton 10f. Zip Code 20784			10g. Citizen d	of What Cour			
900	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. 13.	. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ace - Americ lack, White, o	etc.		
1215-0	thin 72 hou ne. than "natu ne Medical	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occup e kind of work done o DO NOT use retired)	ation during most of wo	rking	16b. Kind of				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once.	To Be C	12 Man: 17. Father's Name (First, Middle, Last) August J. Geiger	ager	ger Safeway Store 18. Mother's Name (First, Middle, Maiden Surname) Margaret Moore						
	d 2 should alth and M 27 is mar or traumat		1		Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrollton Pkwy New Carrollton, MD 2078						
Baltimore,	Page 1 an nent of He ant: If iterr ıry or othe		The Daties 2 and Ordination of the French Country of the Country o	position (Name of ematory or other place Heaven Cen	i	Date 17/2012	20c. Location	•	own, State		
Balti	permit. Par Departmer Important any injury once.		21. Signature of great Service Licensee	22. Name and Addres	ss of Facility Re	endon/Ha	le Fune	eral H			
23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory chock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition as uncondition as uncon									Approximate Interval Between Onset and Death		
100	Medical Examiner	<u>بر</u>	Due to (or as a constituence of):	NO COLICOI							
	ecuted and I-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
8760	ificate be executed g physician and as the burial-transit	edical	d								
Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	Physician/M		☐ Ectopic pregnanc	у			Date of delive	ery Day Year		
ls, P.O.	uires that the name of the signed by the detailed by the detailed by the detailed by the signed by t	ğ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.				ne cause of death? bably 4X Unknown		
of Vital Records,	The law require ate has been si page 2 should	Completed	Somplete	Somplete				24a. Was autoj perfo 1 ☐ Yes	psy		psy findings available mpletion of cause of
/ital	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 EP/Outpatie	Othe	ace of Death (Che		donos 6 🗆 O	thor/Cassifu	d		
	Attending Physician: ar death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) (Month, Day, Year) 28b. Time of injury	of 28c. Injury work	/ at	sing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
Division	tal or Atters after dear al Director	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	nber or Rural	Route Number,						
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in L	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inve	estigation, in my opinic le, death occurred at the	on, death occurred he time, date and p	at the time, date a	and place, and o	due to the cau	use(s) and manner stated		
			29b. Signature and title of certifier Decelyne Koucetcheu, ms	D & 29c. License			29d. Date sign	ed (Month, L	Day, Year)		
_	1054		30. Name and address of person who completed cause of death (Item 23a) (Type, Jocelyne Kouatchou, MD 201 East Ur		Pkwy Ba.	ltimore,	MD 212	218			
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	aske							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 15, 2012 Year 7:55 p.mM. David Lee Houck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's 21552 Searfoss Court Lexington Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Director** 162-38-3093 1 XM 2 F 02/11/1960 Usual Residence of Decedent Pennsylvania 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a Funeral 21552 Searfoss Court 20653 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Supply Specialist Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Lester Houck Edith Arlene Fryberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Jo Houck/Wife 21552 Searfoss Court, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1
Burial 2 X Cremation 3
Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 08/21/2012 | Charlotte Hall, MD Signature of Tuneral Service tensee

Michiele Brinstield Brinsfield Funeral Home, P.A. Road, Leonardtown, MD 20650 MU1652 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Ph, sician/ Medical resulting in death) Due t or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death g ☐ Unknown the a 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe death? After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident injury work?
1 Yes 2 No 5 Pending s after death. Μ Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check within 2 To the 1 29b. Signature and title of certifier H005575

7 the State

DHMH 17 Rev 06-2011

Registrar

30. Name and address of pers

Jennifer

Date filed (Mo

Schmidt,

40900 Merchants Lane, Leonardtown, MD

who completed cause of death (Item 23a) (Type, Print)

D.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ Month 23, 10:30 a.M. Carroll Hall August James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 21028 Little Girls Way Lexington Park Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Min. Director 561-52-3886 1 X M 2 □ F 71 10/14/1940 Usual Residence of Decedent Missouri permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🌠 No Lexington Park Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21028 Little Girls Way 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Pest Control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Thomas Hall Helen Crow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly E. Cook/Daughter 26010 Christine Way, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 08/25/2012 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician, METASTATIC SHALL CELL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physiclan and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury work?
1 Yes 2 No filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 [Left Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 68846 KINN, MD 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Apene Amir Khan, M.D. 25500 Point Lookout Road, Leonardtown, MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mor

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Karen Henderson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rehad and wicomico MURSINA me If Under If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 056-54-2041 Days Hours Country) Director 1 □ M 2 🕱 F Usual Residence of Decede 12/21/1956 New York 28a-f show Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f sho any injury or other treumatic event, the Modical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico 1 X Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Civic Ave. 21804 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Completed Specify: White Baltimore, Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Everett Oppel Elaine Ryer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Oppel/Brother 6980 Cromwell Ave., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 🙀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Stewart Funeral Home by Holloway and Downey, P.A. West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 disease or condition 2665 Medical resulting in death) Due to (or as a consumence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Yes 2 No a | Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown peen 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO ၉ 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

neral Director: After this
y filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Esodulia

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

16

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Ayonth ENRY 2.10 A M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary of Holy Cross Burtonsville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min. Months Hours **Director** 214-28-9161 1**X** M 2 \square F 8/17/1924 87 Washington, DC Usual Residence of Decede with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Montgomery Spencerville 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 16410 Batson Road 20866 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1涨 Yes 2 □ No If Yes, Give Year or Dates. **1943–1945** Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced "natural" Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) General Laborer Navy Ordiance 7th US Armed Forces alth and Mental Hygie

27 is marked other

r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence Harrod Louise Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other tra Chris Harrod/son 4 Joyceton Way, Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State No Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Important: If any injury or once. Round Oak BC Cem. 8/17/2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snow en Funeral Home Funeral Service Liquinse Signatur 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ETASTATIC Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Disability for each management of cause. Enter Underlying Cause (Disease or injury that initiated events Exam the burial-transit certificate be executed and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 use as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pics.
5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 No detached 9 Unknown Unknown been signed by ta should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should EBILITY 24b. Were autopsy findings available 24a, Was an has prior to completion of cause of death? autopsy performed within 24 hours after death.

To the Funeral Director. After this certificate I

Completely filled in by the funeral director name 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes a No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28595

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year)

AUG 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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Registrar's Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 59 SEPHINE HOD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SPRING PITIAI SILVER MONTGOMERY If Under 1 Year Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours Min Director 215-38-515 1 M 2 N 06,06,1938 Washington, D.C Show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director be notified 28a-f 1 Yes 2 No MONTGOMER SPRING ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a edical Examiner must b 709 209 BARKER 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced BLACK Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Şecondary (0-12) College (1-4 or 5+) disabla disab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hodge Franklin Wal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS HOSPITA FORRST 002 RD SPRING MD 28910 item 2 GLEN 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or ott
once, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Washinaton, DC 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee WH Bacon Funeral Home 22. Name and Address of Facility Wanda C. Bacon CC0361 Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ GAST ROINTE STINAL HEMORKHIGE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for se a conceduance of e burial-trans law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician; The law requires within 24 hours after death.

To the Funeral Director. After this certificate has been signored to the Funeral Birector. After this certificate has been deather the Funeral director, page 2 should the strength of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only опе) examiner? 2 No Hospital Other: မ 1 Tes 1 Inpatient 2 NER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify, 27. Manper of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month, Day, Year) MD D 24348 09 20/2 Name and address of person who ompleted cause of death (Item 23a) (Type, Print) MD 1500 FOREST CLEN RD SILVER SPRING HO 20910 ermah Day, Year) 31. Date filed (Month State AUG 17 2012 Registrar

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r 28a-l	Ulrector	10e. Street and Nu	mber				10f. Zip	Code			10g. C	itizen of What	Country?	
limore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene at tast: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mental Examiner must be notified at once.	<u>=</u>	13605 Am	bassad	lor Drive	cedent Ever in	11S 113 V		20874	nic Origin? (S	nacify Vas or			States American Indian, Black,	
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687(ertifica	2	3b. Was decedent past 12 months	pregnant in th	ne 1 Live b	pirth	2 🔲 F	etal death	3	Ectopic pregna	ancy		3d. Date of de Month	Day Year	
Sox death of attent for us	385	1 Yes 2 N	lo 9 🔲 Uni		ant at time of down	leath 5 (Other (Spe	cify)			- 3			
Division of Vital Records, P.O. Box 68760, rat or attending Physician: The law requires that the death certificate be an Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burnarification: To Be Completed by Divisional Machinerical Physician Modern		Part II. Other signif	icant condit	ions contributing to	death but not	resulting in the	underlying	cause give	en in Part I.	_	_		te to the cause of death?	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Directoring Madical Expendical	5 2 5 1	29a Cortifier	Certifying P	hysician: To the bes	at of my knowle	dge, death occ	urred at the	time, date	and place, and	due to the ca	use(s) a	nd manner as	stated.	_
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	1	30. Name and addre	ess of person	who completed caus	se of death (Iter	m 23a)		J. J. 111.1	-			J 20, 20		
		Patricia Aror	nica-Polla	k MD. Assista	ant Medical	Examiner		Baltimo	re Street, E	Baltimore, I	MD 21	223		
Stat Registra	e ³	31. Date filed (Mont	Day Year)	2012 Jens	egistrar's Signa	re par	Kall .	d,						

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1325 M Physician/ ,2012 Beverly Jane Hines Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours 214-28-0994 Director 1 M 2 X F April 14, 1931 Maryland 81 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏋 Yes 2 □ No Maryland Washington Hagerstown 23a o . be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 143 Alexander Street U.S.A. 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Everett Caleb Long Ruth May McCarter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna R. Harding/daughter 741 Anderson Road Magnolia, Delaware 19962 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🕅 Burlal 2 🗆 Cremation 3 🗀 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 08/24/2012 Hagerstown, Maryland Rest Haven Cemetery Signature of Funeral 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1 Enter the disease, or con ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shook, or heart failure, List only Immediate Cause (Final Ph_{sician}/ disease or condition resulting in death) Medical (or as a consequence of Examiner MOLVY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or a consequence of) -tran and that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy for in the past 12 months? Dav Year 5 Other (specify) igned by the at be detached for 2 🗆 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 Ko 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 1 Yes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred eral Director: After I filled in by the funer 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after c 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 20a Certifier (Check 3 Certifying Nurse Practitions my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

CZ

29b. Signature and title of certifie

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

MO

3

29d. Date signed (Month, Day, Year)

Yennsylvania Ave, Hagerstown

12-06283 Joseph Grant Holder Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 28250

		1- For State Registrar		Certific	ate of L	Death		7.5	Reg. N	No.		
Physic		ian/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year								3. Time	of Death	
Medical Exan	nine	COOLLII CIVATAL II						Aug	ust 20, 20)12	1915	hrs
1		4a. Facility Name (if not institution Suburban Hospital	n, give street and number)		City, Town, o Bethesda	or Location of	f Death		4c. County of Montgom		
Funera		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last bir		If Under 1 Ye		_	te of Birth (M		9. Birthplace (S	tate or
Directo	r	577-88-1552	1 XM 2 F	53	Yrs.	Months Da	ys Hours	Min. 04	1/21/1		Foreign Country)] \	MD
A	1	Usual Residence of Decedent										
bw any		10a. State 10b. County		10c. City, Town								de City Limits
yland n-f sh	غِ	MD Montg	diety	Bethes								es 2 No
e Mar or 28,	Director	7618 Bells Mil	l Dood		1	Of. Zip Code				Citizen of What	t Country?	
vith th			12. Was Decedent	Ever in U.S.	142 144 5	20817				SA ————		
21215-0036 Id be filed within 72 hours after death with the Maryland marked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Ma	Armed Forces	?				n? (Specify Ye Puerto Rican, e		14. Race - A White, e	American Indian etc.	, Black,
ifter d 17, or	<u>F</u>	3 Widowed 4 X Dive	1 Yes 2 orced If Yes, Give Year	X No	1 Ye	es 2 X No	specify:			Specify:	White	
ours a	d b	15. Decedent's Education (Spec	ify only highest grade cor	npleted) 16a.	Decedent's	Usual Occupa	ation (Give ki	nd of work don	e 16b	Kind of Busin		
16 172 h 12 h 12 h 12 h	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)		of working life	e. DO NOT u	se retired)				
within giene.	E	11th		Pa	inter					M Pair	ting	
al Hyg	Be C	17. Father's Name (First, Middle, John Henry Hold	•					Name (First, N	,	en Surname)		
21215-0036 und be filed within 7 Mental Hygiene. marked other than	T B	19a. Informant's Name/Relationsh		198	o. Mailing Ad	ddress (Stre		s Gail		City or Town	State, Zip Code	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. "It if tiem 27 is marked other than "natural", or items 22a or 28a-f shown or other traumatic event, the Medical Examiner must be notified at once.	-	Jeffrey Michael	l Holder/son					e, Rich				'
l and Healt Healt fittern or tran	1	20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place of		(Name of ce		Date			ty or Town, Stat	e
MO Pages ent of nnt: I		4 Donation 5 Other Sp		1			SVC	08/23/2	012 H	ramore	MD	
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: Uriten 27 is marked other tinjury or other traumatic event, the Med		21. Signature of Funeral Service		2	22. Nam	e and Addres	s of Facility	Snowde	n Fune	eral Ho	me	
		Dearge The	Lasuden	R.	246	N. Was	hingto	on St,	Rockvi	ille, M	D 20850	ı
Physician // /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	complications that caused on each line.	the death. Do no	t enter the n	node of dying	such as can	diac or respirat	tory arrest, s	hock, or heart		mate Interval n Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a Intracere		orrha	ge						Death
			Due to (or as a conse	. ,	rosc1	eretic	Cardi	03700031	lam Di			
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		TOBCI	CIUCIC	Carui	.ovascu.	Tal DI	sease		
D.	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a conse	orugnes of):							_	
scuted and A transit		events resulting in death) Last	d.	querice or).								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the kinneral director, page 2 should be detached for use as the burial - transit	/Medical	X UNPENDED	AMENDED 23a-	-b,pt.II	,27,p	er me,	g933 1	1-29-12	2 sm			
376(ficate g phy-	¥ /	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	, •					2:	3d. Date of del		
Box 68 e death certif the attending ed for use as	icial	past 12 months?	1 Live birth 4 Pregnant at	time of death 5		leath 3 (Specify)	jEctopic p	regnancy		Month	Day	Year
Bo e deat the at ed for	Physician	1 Yes 2 No 9 Unkr	9 Unknown			_			_			
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cords law requi has been 2 should	Completed							24a.	Was an autopsy	prior	e autopsy findin to completion o	
Rec The 1 cate bage	통	•						1 🗸	yerformed?		h? Yes 2	No
Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medical examiner?	Hamital:					heck only one)				
Physic Physic er this ral din	ျ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		tpatient 3			lursing Home			ther:	
on of oding Ph. ft. After to funeral	<u>e</u>	1 X Natural 5 Pendir	28a. Date of Injur (Month, Day,Ye	y 28b. I	ime of Injury		ryatWork? ′es 2 ∏ No		scribe how in	jury occurred		
isior Attend ar death rector: by the	icat	2 Accident Investi	gation 28e Place of Init	Inv. At home, far	m street fo				1011	N		
Divisipital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could 4 Homicide determ	not be	ary remonie, ici	m, succi, la	ciory, office b	allaling, etc.		own, State)	and Number of	Rural Route N	amber, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		20a Cartifier	sician: To the best of my	knowledge, deat	th occurred a	at the time, da	te and place	, and due to the	e cause(s) a	nd manner as	stated	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam	iner: On the basis of exam	ination and/or in	vestigation,	in my opinion	death occur	red at the time	, date and pl	ace, and due to	o the cause(s)	
	ž	29b. Signature and title of certifier				29c. License			29d.	Date signed (Month, Day, Yea	ir)
		Theodore !	M. King	JR	, λ	O.C.N	M.E.	OGME	Aug	gust 21, 20	12	
		30. Name and address of person w			``\\\							
	212	Theodore M. King, Jr., I		_		reas	ore Stree	t, Baltimore	e, MD 212	23		
St Regist	_		2012 32. Registrar	s signature	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylanc					lental Hy	giene		
			State Registrar			Cer	tificate o	f Death			Reg. No.	2012	2825
	Physicia	in/	Decedent's Name (First, Middle							2. Date of De Month	Day	Year	3. Time of Death
A. G.	Medic	al		Hemmer					4	Month OS	15	2012	8:52 PM
	Examin	er	4a. Facility Name (if not institution Vniversity of M		Telle	uter	4b. City, Town	or Location		Th.	4c. Cou	nty of Death	
	Funeral		5. Social Security Number		e (In yrs. las		If Under 1 Ye	ar If Unde	er 24 Hrs.	8. Date of Bir		9. Birth	place (State or Foreign
	Director		273-54-9276	1 🖾 M 2 🗆 F	54	Yrs.	Months Da	ys Hours	Min.	(Month, Da		Ohio	**
	nd now at	_	Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation		1	12/30/	11931	1	Od. Inside City Limits
	arylar la-f sl	Funeral Director	MD Princ	e George's		n Dal							1 ☒ Yes 2 ☐ No
	or 28 e not	ä	10e. Street and Number		0_0		10f. Zip Cod	le	_		10g. Citizen	of What Cour	ntry?
	with s 23a ust b	era	8105 Willowgat	e Place			20769					US	A
	death item ier m	Fur	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify C	of Hispanic O	rigin? (Spec	cify Yes or No-	14. F	Race - Americ	
36	after I", or xamir	d by	1 Never Married 2 X Ma 3 Widowed 4 Divorced	ried 1 Tes 2 X	No		Yes 2 🛚			,	Spec	Black, White,	
21215-0036	nours latura ical E	Completed		Year or Dates.		16a. Deced	lent's Usual Oc	cupation				f Business/In	nite
215	n 72 l e. an "r Me di	dm	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4 or 5	(+)	(Give I	kind of work do O NOT use retir	ne during mo	st of workin	ıg	TOD. KING O	Dusiness/iii	dustry
21	withi /giene ner th		Liomonary observatry to 127	5+	'	Senio	r Spect	ral Sc	ienti	st	Resear	rch Sc	ience
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7	uld by d Mer mark natic		Robert Hemmer						Simo				
Maryland	2 sho th and 27 is r traur		19a. Informant's Name/Relations		1/4		g Address (Stre				-		
ē,	and Heal tem ?		Margaret T. He 20a. Method of Disposition	nuner / wire	20b. Pla	ce of Dispo	Willowg sition <i>(Name of</i>			ate		on - City or To	
mo	age on the same of		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (1	**	natory or other tan Cre					•	Virginia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		THECH		. Name and Ad	-		7/12			more Avenue
<u> </u>	B B E B		Loy Leket			G	asch's	Funera	1 Hom	e, P.A	_		e, MD 2078]
			23a. Part 1 Enter the disease, o shock, or heart failure. List			Do not ente	er the mode of o	dying, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Between
4	h, sician/		Immediate Cause (Final disease or condition	_a Ac	utel	myel	vid Le	nker	nia				Onset and Death
2007	Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	nce off:						-	
	ted I Insit	Examiner	Cause, Enter Underlying Cause (Disease or injury	540 10 (01 43 5	Conseque	1100 01).							
	execu an and rial-tra	EX	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):							
09	te be executed hysician and he burial-transit	dical		d									
6876	tificat ng ph e as th	Med	IF FEMALE:	T									
9 X	eath certificat attending ph for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal (death 3	Ectopic pregr					Date of delive	ery Day Year
Вох	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant at 9 ☐ Unknown	time of de	ath 5∟	Other (specify					WOITH	Day Teal
P.O.	es that the dea signed by the a I be detached I	y Ph	Part II. Other significant conditi	ons contributing to death b	ut not resul	ting in the u	nderlying cause	given in Par	t I.	23e. Did to	obacco use co	ontribute to th	ne cause of death?
<u>S</u> ,	uires t 3 sign ild be	ed by								1 🗆	Yes 2 No	o 3 🗆 Prot	oably 4 🗆 Unknown
orc	w require s been sig 2 should b	plet								24a. Was		b. Were auto	osy findings available
3ec	The law ate has page 2	Completed									ormed?	death?	mpletion of cause of
e	ysician: The is certificate director, pag		25. Was case referred to medical examiner?				26	. Place of De	ath (Check		2 0 1101		
of Vital Records,	Physic this ce	ျှ	1 Yes 2 No	The state of the s			t 3 🗆 DOA	Other: 4 🗆 N	lursing Hon	ne 5 🗆 Resid	dence 6 🗆 C	ther (Specify	,
0 ر	ding Phy h. After thi funeral	Certificate:	27. Manner of Death 1 X Natural 5 □ Pendi		y ; Year) 2	8b. Time of injury	l v	njury at vork?	- 1	8d. Describe h	now injury occi	urred	
Sior	ttendi death. stor: A y the fi	tific	2 Accident Investi	not be 280 Place of Inju	ny - At hom	o form etro		Yes 2	_	Of Location (C	Street and Alice	nhar ar Puml	Route Number,
Division	l or A after Direct		4 Homicide determ	building, etc		o, ram, stre	et, lactory, only	36	'	City or Tow		riber or nurar	nodie Nambei,
П	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowled	dge, death c	occurred at the	time, date an	d place, and	d due to the ca	ause(s) and ma	anner as state	ed.
	he Ho iin 24 he Fu iplete	Mec		xaminer: On the basis of ex Nurse Practitioner: To the									
	North Voith COT		29b. Signature and title of certifie	lledidi	1415	110		ense number			29d. Date sign		
7	10		1 0/1					0313	1566	7	High	wt 15	12012
	-Tim		30. Name and address of person		eath (Item 2	3a) (Type, P	rint)	MP2	1201				
	Stat	e	31. Date filed (Month, Day, Year)					-					
	Registra	_	AUG 2 0 2	012 Sentra	A.	par	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August 4:44 PM 2012 Carolyn Jones Howard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kegional Hospital aure Prince George's .aurel Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min Director 220-50-1949 1 🗆 M 2 🗓 F 64 8-19-1947 Georgia 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 28a-f 1 XYes 2 No DC Washington ь 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 921 E Street SE 20003 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏲 No n "natural", or iterr ledical Examiner r 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) DC Public School Sys. Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filk thent of Health and Mental rant: If item 27 is marked or n and Mental I Mental ဂ္ Walter Jones Addy Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adora Wilmore/Sister 11400 Belvidere Rd. Bowie MD 20721 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation Removal from State Chesapeake Crematory | 8-16-2012 Donation 5 - Other Beltsville, Maryland (Specify 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 M01592 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HY Poxid disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** percarbio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine physician and s the burial-transit Severe Metabolic Acidosis Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 use as attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by perKalemia Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 2 🗌 No 1 🗌 Yes completely filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 00012962 August 20, 2012 Dusen Rd. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Lee-Llacer, MD Regional Hospita Laurel ordydd

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28256 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Derrick Harvell ACUCU St 2-20 A M Zŏ 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 216-11-4407 Director 1 🖾 M 2 🗆 F Usual Residence of Decedent 42 March 26, 1970 28a-f show 10h County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland | Prince George's Forestville 1 X Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20747 United States 1311 Inland Drive death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 X Never Married 2 Married Black, White, etc. δ 2 **X** No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates ntal Hygiene. ted other than "natura s event, the Medical E 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygien 12th Interior Decorator Management Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gracie Beadle Gettie Harvell injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13164 W. Shenandoah Trail Wadsworth, IL 60083 Eric Harvell - Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Suitland, Maryland Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Rejection of cardiac transplant disease or condition resulting in death) Medical Examine nm-ischemic Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) In the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year , the Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 autopsy page performed?

Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes မြ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this 27. Manner of Death nours after death.

neral Director: After the filled in by the funera Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1518201062 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GREENE STREET, BANTIMORE, MD 21201

Registrar DHMH 17 Rev 06-2011

State

Monique Alwanth

31. Date filed (Month, Day, Year,

AUG 2 2 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 William Hatton III Norman 7:18A August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince Georges Hospital Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min Director 218-35-3064 1 3 M 2 □ F 1992 Wash.,DC 20 May 21, Usual Residence of Deceden 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 No MD Waldorf Charles 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20603 10394 Hallmark Lane items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. P þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Private Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shantell Spivey Norman W. Hatton Jr and 2 should be Health and Meter 27 is mark 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10394 Hallmark Lane Waldorf, MD, 20603 Shantell Marion/Mother item 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 8/11/12 permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Harmony Mem Park Landover, 21. Sign wre of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. Silver Hill Rd., Suitland, MD. 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Onset and Death Ph. sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a con that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and -trar Due to (or as a consequence of) attending physician for use as the buris Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ 100 Day Month Year Pregnant at time of death the 9 Unknown P.O. þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? certificate Yes 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death iours after death.

ieral Director: After the filled in by the funera 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 643 M Investigation 10/2 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Ru Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State K BrANCH within 24 hours a

To the Funeral E

completely filled Medical Certifying Physician: To the best of my Krie 29a. Certifier rledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examinat (Check Certifying Nurse Practitioner: To the best only one) 29b. Signature a d title of certi 29d. Date signed (Month, Qay, Year)

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State Registrar and address of pe

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar 28258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 2012 5:30 THSAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BETHESDA SUBURBAN HOSPI MONTGOMERY 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) 212-15-8404 Hours Min Month, Day, Year) **Director** 1 X M 2 🗆 F 8 05 INDIA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BETHESDA 1 XYes 2 ☐ No MONTGEMERY MD 10e, Street and Number 10g. Citizen of What Country? Funeral 20817 CHARLESTON USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced ASIAN 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) PAKISTAN EMBASS DIPLOMAT Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည NABT BUKSH AZiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/742 MAZHAR EMERSON DR. HAGERSTOWN MD. 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition injury or Burial 2 Cremation 3 Removal from State Department Important: If any injury or 114/2012 FREDERICK MD Donation 5 Other (Specify) 21. Signature of Funeral Service Linense Ho#1070 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER STREET WOODBRIDGE 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure Respuratory disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Sequentally just continuous if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autoosy performed? Yes 2 No death? 2 🗆 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of cent 72726 08-13-2013 of person who completed cause of death (Item 23a) (Type, Print) Bethesda MD 20814 MD 8600 Old Georgetown 31. Date filed (Month, Day, Year)

AUG 1 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2110 pM <u>John Lee Jones</u> Medical ALIC 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ft. Washington Hospital Washingtor Georges 8. Date of Birth (Month, Day, Year) Dec 22.1 5. Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Days Months Hours 579-30-7755 Director 1928 Wash DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 Yes 2 No Prince Georges Ft. Washington 10e. Street and Numbe 10q. Citizen of What Country? Funeral 7908 Winnsboro Drive 20744 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 r than "natural", or 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the FEMA US Government marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Charles Jones Georgiana Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 DuWayne Jones - son 18373 Eagle Point Sq., Leesburg, Va 20176 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2012 Important: If if any injury or c 1 X Burial 2 Cremation 3 Removal from State Arlington Natl. 4 ☐ Donation 5 ☐ Other (Specify) Nov 14, Arlington, Va. 22. Name and Address of Facility Eternal Faith Funeral Sv 21. Signature of Funeral Service Lice see MO1 Southern Md. Blvd. Dunkirk. Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ cardopulmonay ares disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural (Month, Day, Year) within 24 hours are use to the Funeral Director. After the Funeral Director. 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 8 MD B D00576 32 and address of person who completed cause of death (Item 23a) (Type, Print) LIVing Ston Rd ms 31. Date filed (Month, Day, Year) State AUG 20 Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28260 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0237 Avgust Jenkins Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number If Under 1 Year **Funeral** (Month, Day, Year) N/A 1**X** M 2 □ F Director 3 August 15,2012 Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Temple Hills 1 XYes 2 No Md. P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 U.S.A. 2804 John A. Thompson Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 ₺ Never Married 2 ☐ Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Watson Jenkins Dionne Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 John A. Thompson Road, Temple Hills, Md. 20748 Dionne Watson - Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 08-24-2012 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor, II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Entracrania nemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the page 2 should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? perrormed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 🖾 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🗹 No 1 Yes 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 29c. License number RES-UUC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Baltimore MD 21297 32. Registrar's S. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28261 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Benjamin F. James ,2012 1054 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges . Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 247-24-6709 Director 1 **X** M 2 □ F Sept.10,1922 89 SC show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No DC Washington 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral 1711 D St., SE 20003 United States items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ö ☐ Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", 3 X Widowed 4 □ Divorced Specify: Completed Black event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Printing Plant Worker Bureau of Engraving Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental His marked of ပ္ traumatic Mary Thomas Samuel James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 7216 Lansdale Street Rosslyn Wallace/Daughter District Heights, 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 8/17/12 Clinton, MD Si atur of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ Por in the past 12 months? Month Yea Pregnant at time of death Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 1 No Yes 2 No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 K ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pletely (Check Certifying Nurse Proditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

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31. Date filed (Month. Day, Year,

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Dry Cheverly

, MD

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M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nelson

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Month 5 Day 1. Decedent's Name (First, Middle, Last) Physician/ Jada Nichole Keiffer Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO 3AU/364/9 REGIONAL TENINSKLA If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Min Days n/a 1 □ M 2 🗡 F Director -05 2010 Maryland Usual Residence of Decede 28a-f show 10a. State 10c. City. Town or Location Director notified 1 Yes 2 X No Maryland Wicomico Eden 10f. Zip Code 21822 10g. Citizen of What Country? ö ms 23a or must be r Funeral 4055 Joseph Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any lajury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Brenda Nichole Olivares James Wesley Keiffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bre'Ayna De'Juan Jones/Aunt 7503 Barton Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 8/15/2012 Salisbury, MD Donation 5 - Other (Specify) 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 art 1. Enter the disease, or compli caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca Sivere ischaemic hypoxemic insuls to ou body tissues peath mediate Cause (Final Ph_sician/ disease or condition resulting in death) severe hypoxermic ischoemic encepholopoetry. Medical Examiner sevara acidiosis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Severe hypoxemia that initiated events and burial-trar The law requires that the death certificate be execu resulting in death) Last physician Physician/Medical Absence of effective heart rate for more than Division of Vital Records, P.O. Box 68760 the the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 X Yes Hospital or Attending Physician: 24 hours after death. completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural
Accider
Suicide iniury 5 Pending Accident Investigation Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar Carrell

100

ST. Salisbury MD

ame and address of person who completed cause of death (Item 23a) (Type, Print)

KANDIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lawrence Edward Kile 2012 August 5:30 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5614 Indiantown Road Rhodesdale Dorchester Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F 52 April 16, 1960 221-46-6245 Pennsylvania **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 No Maryland Dorchester Rhodesdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 5614 Indiantown Road 21659 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 iment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Metal Fabricator Manufacturing Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ٩ Ranson Edward Kile Mary Ann Gavlick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia T. Kile/Wife 5614 Indiantown Road, Rhodesdale, MD 21659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Date 1 Burial 2 X Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Crematory Of Delmarva 8/15/2012 Delmar, Delaware 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Signature of Funeral Service Land any Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Interval Retween Immediate Cause (Final Onset and Death Phylician Amyotropic (Due to (Fr as a consequence of): disease or condition sclerosis lateral Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery for in the past 12 months? Day Pregnant at time of death Yes 2 No signed by the 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident after death Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar Cuc Amit DD

Curtis A. Smith P.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

C20003304-Delaware

314 South Central Ave Laurel Delaware

8/15/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11em 25 per me 9931 9-11-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August Physician/ William Charles Keller 2012 1:25 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Hours Director 93 200-05-3523 1 XM 2 - F 01/05/1919 Pennsylvania ms 23a or 28a-f show must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Gaithersburg Montgomery 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20882 8701 Lochaven Drive United States "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 2 No 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 🗌 Widowed 4 🗌 Divorced 1979 Specify: White Year or Dates is marked other than "natural aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Joanne(Hannah)Elizabeth Tretter Henry Frank Keller 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 9813 Greenbrier Lane, Walkersville, MD 21793 Lois Ann Keller-Poole (Daughter) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
St Marys Catholic
Cemetery 1 X Burial 2 Cremation 3 Removal from State August 28, 2012 4 ☐ Donation 5 ☐ Other (Specify) St. Marys, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, A. STUVER M01117 RACY Gaithersburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) onsequence of) **Examiner** abscess una Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a co squence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Kecurrent PAROVED BY MEDICAL EXAMINE and that initiated events resulting in death) Last the attending physician CERTIFICATION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has performe 2 🗌 No Yes 2 X No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?

1 XYes Hospital Other: ည 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 1)69148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Molecular Drive Suite 206 Rockville. Marichu Matas 10/10 31. Date filed (Mo A) Registrar's Signatur State 9 Registrar

12-06033 Eun Ju Kim Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Registrar	ertificate of			R	eg. 140.	2 2826
Physici ledical Exami	an/ iner	1. Decedent's Name (First, Middle,Last) Eun Ju Kim				2. Date of Dea Month August 12		3. Time of Death 0300 hrs
		4a. Facility Name (if not institution, give street and number) 8108 Warfield Road		b. City, Town, o Gaithersbu	or Location of Deat		4c. County of Death Montgomery	
Funeral Director		227-37-6052 _{1 M 2XF}	s. last birthday) 47 Yrs.	If Under 1 Ye		_	th(MM/DD/YYYY) 9. Bird 13, 1965 Foreig	hplace (State or n South ^{untry)} Korea
Maryland 28a-f shnw any 3 at once.	or	VA Fairfax A	ity, Town or Locati Annanda					10d. Inside City Limits 1 Yes 2 X No
the Maryl 3a or 28a-	Director	10e. Street and Number 8607 Dora Court		10f. Zip Code 2200	3	1	0g. Citizen of What Cour	ntry?
y, MD 21215-0036 and 2 should Hilper within 72 hours after death with the Maryland tealth and Mould Higgie within 72 hours after death with the Maryland ten 21 is marked other than "matural", ar items 23a or 28a-f shu traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Pates:	If Ye		lispanic Origin? (S an, Mexican, Puerto o s <i>pecify:</i>		14. Race - Ameri White, etc. Specify: Asi	
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21215-0036 suld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Young Chul Kwag			Sun Oa	ak Ki	Maiden Surname)	
MD 27 nd 2 should alth and Me m 27 is ma	ይ	19a. Informant's Name/Relationship (Type, Print) Shin Kim/Husband	8108	Warfie	eld Rd.,	Gaithe	nber, City or Town, State, ersburg, MD	20882
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or ather traumat		1 Burial 2 X Cremation 3 Removal from State F 4 Donation 5 Other Specify:	b. Place of Disposi crematory or oth airfax uneral	erplace) Memori Home	al Aug	112	Fairfax,	VA
Ball permit Depart Impor	1	21. Signature of Funeral Service Licensee The Best Service CC0423					Memorial .,Fairfax	Funeral ,VA 22032
Physician /Medical Examiner		And I. Enter the disease, or complications that caused the dea failure. List only one cause on each line. Immediate Cause (Final disease a, Hanging	ith. Do not enter th	e mode of dying	g, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence Sequentially list conditions,	•					
0	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
and		events resulting in death) Last Due to (or as a consequence d.) of):					
60, ate be ex hysician e burial	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pre	egnancy				23d. Date of delivery	
Box 687 e death certific the attending p ed for use as th	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown	2 Feta	al death 3 er (S <i>pecify</i>)	Ectopic pregna	ancy		ay Year
P.O. ires that the signed by the detache	2	Part II. Other significant conditions contributing to death but not	t resulting in the ur	nderlying cause	given in Part I.		bacco use contribute to t	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and brompietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed					24a. Was a autop perfor	sy prior to co	opsy findings available ompletion of cause of
/ital /sician: /sician: /sician: /sician:	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient		e of Death (Check		Residence 6 🗸 Other:	Scene
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Vompletely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Single Fa		, factory, office	building, etc.	or Town, S	Street and Number or Runtate) Road, Gaithersburg,	
o the Ho ithin 24 o the Fu	Medical	Check only one) 2 Medical Examiner: On the basis of examination and manner stated,						
15	We	29b. Signature and title of certifier The obey We Way The	2. 14.00	29c. Licens	M.E. OCA	Q pro-	29d. Date signed (Mon August 12, 2012	th, Day, Year)
		30/Name and address of person who completed cause of death (Ite Theodore M. King, Jr., MD. Assistant Medical		00 W. Baltir	more Street, B	altimore, MD	21223	
St Regist	ate rar	31. Date filed (Month, Day, Year). 32. Registrar's Signal AUG 10 2012	ature parks	1),				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Hernandez Lopez 08/11/2012 07:40 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** None Min Hours (Month, Day, Year) 10/09/1961 1 □ M 2 😿 F **Director** 50 Honduras Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Md Prince George Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? 8216 18th. Ave. 20783 Honduras permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Honduras Specify: Hispanic Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) ar than ", the N Elementary/Secondary (0-12) 12th Department of Health and Mental Hydral Inportant: If item 27 is marked other than any injury or other traumatic event, the Nonce. College (1-4 or 5+) Housekeeper Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Unknown Rebeca Hernandez 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8216 18th. Ave. Hyattsville, Md 20783 Emanuel Hernandez/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 08/23/12 Honduras Cemetery ignat of Funeral Service Licens 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Washington D.C. a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Due to (or as a o **Examiner** Sequentially list conditions, Examiner Fusite for as a pe cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director. After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buyga-transit the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 5 Other (specify) Day Year 9 Unknown g Unknown ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury 2 Accident Investigation M 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Registrar DHMH 17 Rev 06-2011

State

within 24 hours a

To the Funeral C

completely i

Medical

29a. Certifier

DR.

(Check

only one)

29b. Signature and title of certifier

NASREEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License nu

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

7600 Carroll Ave. Takoma Park,

20912

Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla		artment o rtificate o			nd M	ental Hy	giene	2 በ	12	28	3268
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate t	or Dea	<i>au</i> 1		2. Date of De	Reg. No.	20	I Im	3. Time	
	Physicia Medi		Lillian Secundy Lynch					A	August		2012	Year	1:35	P M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Tov						County of			
ميد آ	Funeral		3310 North Leisure World Boule 5. Social Security Number 6. Sex 7. Age (In yrs.		Silve				8. Date of Bir		-	mery		
	Director	ı	577-48-9379 1□M2XF 98	Yrs.					ov. 3		Ne	Count	ork	or Foreign
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	or 28			D _F =	10f. Zip Co	ode				10g. Citiz	en of Wh	nat Count		.5 2 110
	s 23a	Funeral	3310 North Leisure World Boul	evard	209	06						Stat	,	
9036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married 1 Yes 2 X No	If	Was Decedent f Yes, specify (I ☐ Yes 2 🛣	Cuban, M	lexican, P	? (Spec uerto R	ify Yes or No- ican, etc.)			White, e	an Indian, tc. ack	
15-	72 hou n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	dent's Usual Okind of work do NOT use ret	one during	n g most of	f working	g	16b. Kin	d of Busi	iness Ind	ustry	
212	within giene. er tha , the f		Elementary/Seconday (0-12) College (1-4 or 5+) 5+		Lal Wor	,				,	Heal	th		
Maryland 21215-0036	should be filed and Mental Hyg 7 is marked oth raumatic event.	To Be	17. Father's Name (First, Middle, Last) Carl Christian Jorgensen						(First, Middle, Ontier	Maiden Su	ırname)			
	12 shou lith and 27 is m	1	19a. Informant's Name/Relationship (Type, Print) Robert Secundy - Son		ng Address (St									
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E C	Page ment c ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) Che	cemetery, crem		,	8,	/14/	2012	Belt s	vill	e. M	D	
Baltimore,	permit. Page 1: Department of P Important: If its any injury or of	12	21. Signature of Super Servic Acensee	22.	Name and A	ddress of	Facility M	icGu:	ire Fu	neral	Ser	vice	, Inc	
ı			23a. Part 1. Enter the disease, or complications that caused the dea											
				1 / 1	the mode of								Approxima Interval Be	
	Ph_sician/ Medical	þ	23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each life. Immediate Cause (Final disease or condition a. a		the mode of				respiratory an		260		Interval Be Onset and	etween Death
ممييد	Ph_sician/ / Medical Examiner		resulting in death) Due to (or as a consection)		the mode of						Con .		Interval Be	etween Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28269 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 19 ay 2012^{Year} Hilda Levin 9:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Village at Rockville Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Vonths Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Nov. 20, 1921 214-16-9797 90 Mary Land **Director** 1 🗆 M 2 🛛 F Yrs. Usual Residence of Decedent item 27 is merked other then "natural", or items 23e or 28e-f shov other treumetic event, the Medical Examiner must be natified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Rockville 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9823 Veirs Drive 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ٥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 No ould be filed within 72 hours aft. d Mental Hygiene. merked other then "natural", 1 Yes 2 No Specify: If Yes. Give White 3 🕅 Widowed 4 🗌 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Schuebel Mary Charitan should and Me 19a. Informant's Name/Relationship (Type, Print)
Don Levin – Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10726 Cleos Court, Columbia, Md. 21044 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 8/20/2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-Wisconsin Ave., NW . Signature of Funeral Service Lic CC0367 Hysong Co., Inc Washington, DC 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injurithat initiated events resulting in death) Last Hospitel or Attending Physicien: The lew requires that the death certificate be executed ettending physician end for use as the burlal-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months Month Day Year signed by the el 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has the director, pege 2 s performed? Yes 2 No 1 Yes 2 No 24 hours after death.
Funeral Director: After this certifica ietely filled in by the funerel director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: 2 A NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Anath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sjgnature and title of certifier 29c. License number was 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 9701 Veirs Dr., Rockville, Md. 20850 Charles W. Karesh 31. Date filed (Month, Day, Year) State 32. Registrar's Signature AUG 2 🛚 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Hegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
1/:43 P. M Physician/ Katherine A. Lucas-Pittman Medical 00 Facility Name (if not institution, give street and numbe Examiner ocation of Death ynty of Death O MearCH nie If Under 1 Year Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) **Director** 577-68-2412 1 □ M 2 □**X**F 62 Jan. 18, 1950 Usual Residence of Decedent Virginia 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Examiner must be notified 1 X Yes 2 ☐ No Maryland Charles Waldorf 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4836 Castlewood Court 20602 United States 12. Was Decedent Ever in U.S Armed Forces? 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or by Black, White, etc. 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 🔀 No Specify. If Yes, Give 3 Divorced 4 Divorced Specify: Completed Year or Dates Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Counselor 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) 12th College (1-4 or 5+) and Mental Hygiene. the <u>Grand</u>mother Assistant Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unk. Viola Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Annette Lucas - Daughter 4836 Castlewood Court Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of $\overset{\text{Date}}{16}$ 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Lee's Crematory Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Holm M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Thin disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Yes ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 4 JM who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Marylai				lental Hyg	iene	10	20271
			Registrar 1. Decedent's Name (First, Middle, Last)	Certi	ificate of D	eatri	2. Date of Deat	eg. No. ZU	16	3. Time of Death
ľ	Physicia Medic		Sylvia Marie Mast				Month August	17, 20	Year)12	6:45 A M
10000	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of		
744	Funeral	-	38750 Chaptico Road 5. Social Security Number 6. Sex 7. Age //n vrs.	. last birthday)		icsville If Under 24 Hrs.	8. Date of Birth		Mary 9 Birthol	S ace (State or Foreign
2.	Director		212 22 1220		Months Days	Hours Min.	(Month, Day,	Year)	Countr	y)
	nd how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	City, Town or Loca	ation		08/30/	L925	Mary 10	Land Id. Inside City Limits
	Maryla :8a-f s tiffied	Director	Maryland St. Mary's		Mechanic	sville				1 🗌 Yes 2 🗶 No
	the land or 2 be no	a Di	10e. Street and Number		10f. Zip Code		1	I0g. Citizen of W	hat Countr	y?
	uth with ms 23 must	Funeral	38640 Chaptico Road	10 140 144		659	-if . Ves an Ne		ISA	
980	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ledical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	lf Y	as Decedent of Hisp Yes, specify Cuban, Yes 2 No	Mexican, Puerto I	Rican, etc.)	Black	- America k, White, et Whit	c.
5-0	hour "natur dical	plete	15. Decedent's Education (Specify only highest grade completed)		nt's Usual Occupat			16b. Kind of Bus	siness/Indu	ıstry
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Division of Vital Records,	e law r	Completed					24a. Was ar autops perforn	y pr		y findings available pletion of cause of
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ζţ	hysicia his cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2		Other			nce 6 🗶 Other	(Specify)	Residence
n of	ding P h. After ti funera	ate:	27. Manner of D ath Natural 5 Pending Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?		8d, Describe ho	w injury occurred	1	
Sio	Attender deat sector:	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At he	jome, farm, street		es 2 No	8f. Location (Str	eet and Number	or Rural R	oute Number,
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know only one) 3 Certifying Nurse Practitioner: To the best of the	on and/or investiga	ation, in my opinion,	death occurred at t	he time, date and	d place, and due t	to the cause	e(s) and manner stated.
_	vith vith con		29b. Signature and title of certifier		29c. License n	iumber	-/ 29	d. Date signed (Month, Da	y, Year)
			30. Name and address of person who completed cause of death (Iten	m 23a) (Type Prir	1 HCOO	DUTE	>	08-	- 17	-0012
)em	ر ا		Jennifer Schmidt 40900 Mer	, , , , ,	*	nardtown	, MD 20	650		
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			TOTAL TENTE	B	1.50					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Christopher O'Connell Mattingly Medical 11:30a.M August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 44708 Joy Chapel Road Hollywood St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, Year) 213-76-2818 1 M 2 G F Director 05/11/1957 Maryland 28a-f shor 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director be notified Maryland St. Mary's Leonardtown 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral iral", or items 23a Examiner must b 41470 Garrett Court 20650 United States and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Completed 3 - Widowed 4- Divorced Year or Dates. ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Supervisor <u>Medical Equipment</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental marked ၉ 27 is marker treumetic Mary O'Connell Joseph Aloysius Mattingly, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 <u> John F. Mattingly/Brother</u> 41470 Garrett Court, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s
Department of H
Important: If ite
eny injury or ot
once. 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our_Lady's Church Cem 08/24/2012 Leonardtown, Maryland 21. Signature of Fundal Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward W. Brinsfleld, Jr.M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician, Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE | P FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No. No. 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (5) eme Schmidt, 40900 Merchants Lane, Suite 205, Leonardtown, Maryland 20650 Jennifer 31. Date filed (Month, Day, Year) State . Registrar's Signat

DHMH 17 Rev 06-2011

Registrar

AUG 2 2 2012

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Funeral Director		5. Social Security Number 219-26-7448		e (In yrs. last birtl		Jnder 1 Year nths Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			hplace (State or Foreign untry)
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Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Soc		Meadown	y, crematory cidae	or other place Mem. P	e ark 08	8/24/	/2012	Е	Elkridge	e, MD
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	nsee							itzke	's Fami	lly FH Inc.
00 = 60	-	23a. Part 1. Enter the disease, or co	view	No. 10-11 Box							t City	, MD 21043
Physician/ Medical Examiner	Examiner	snock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a	consequence o	REI 1):							Approximate Interval Between Onset and Death
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To the within To the сотры		29b. Signature and title of certifier	Practitioner To the	cost of my know	reage; death	29c. License		and plac			signed (Month)	
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6	- 1	30. Name and address of person wh		· · · · · · · · · · · · · · · · · · ·	ype, Print)	CATO	_W N A	UE,	BAL	T1M	OKE,	MD 21229
State Registra	e r	31. Date filed (Month, Day, Year)	2012 32 gistrar	's Signature	bar	Les les						

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				ertificate of Death		12 28274
Ē	Physicia Medic		1. Decedent's Name (First, Middle, Last) Diana I. Mondragon		2. Date of Death Month August 14, 2012	3. Time of Death 3:11 a M
	Examir		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park	4c. County of	
111	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	9. Birthplace (State or Foreign
	Director		921-81-5986 1 □ M 2 ☑ F 25 Yrs.	Months Days Hours Min.	(Month, Day, Year) June 20, 1987	Country) Honduras
	land show dat	ţō	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
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	with th	Funeral Director	3206 Taylor Street	10f. Zip Code 20712	10g. Citizen of What Honduras	•
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 Yes 2 □ No Specify: Hor	Diack,	White, etc. Vhite
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m	permi Depar Impo any in		* Kehard L. Later	22. Name and Address of Facility Francis J. Collins 500 University Blv	Funeral Home Inc d. W., Silver Sp	ring, MD 20901
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	nd 2 s ealth m 27 i		R. Allen McCrack	en/Husband	4513	Clearbr	ook L	ane, Kensi	ngto	n, MD	208	95	
Baltimore,	ge 1a Int of H In ite or oth		20a. Method of Disposition ¹XX Burial 2 ☐ Cremation 3 ☐	Removal from State Co. 8	Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date 20		Location - C			
Iţi	iit. Pag urtmer urtant njury	9	4 Donation 5 Other (Specify 21. Signature of Juneral Seyid Locense			natory or other place Heaven ery		Aug. 20, 2012				g, MD	
Ba	permi Depar Impor any ir		Turboid Late					ins Funera Blvd. W.,				, MD 2	0901
ш			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the deat e cause on each line.	h. Do not ente	r the mode of dyir	ng, such as o	cardiac or respiratory	arrest,			Approximate Interval Betw	
2	Physician Medical	έą	Immediate Cause (Final disease or condition resulting in death)	a Pneumonia							11	Onset and D	eath
	Examiner			Due to (or as a consequence Acute Renal									
	T-E	iner	Sequentially list conditions, if any, leading to immediate ease. Enter Underlying Cause (Disease or Injury	b. Due to (or as a consequ		-							
	nd nd	Examiner	that initiated events	c. COPD									
	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the by the funeral director.		resulting in death) Last	Due to (or as a consequ	uence of):								
8760	physics the	Medical		d									
89	aath certifica attending ph I for use as t	_		3c. If yes, outcome of pregna	incy					23d. Date	of delive	rv	
Box	death	Physician.	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Feta 4 Pregnant at time of c		Other (specify)	cy		.]	Month			ear
P.O.	es that the des igned by the a be detached	Phy	9 ☐ Unknown Part II. Other significant conditions co		ulting in the u	nderlying cause di	von in Part I	00. 5:					
S,	res thi signer d be c	Completed by	Tark in warm originated contained to	numbering to death but not res	diting in the di	nderlying cause gr	verimi arci.					e cause of dea ably 4 🗍 U	
ord	require been si	lete						24a. Wa				sy findings av	
Records,	The law ate has page 2	omp						aut per	opsy formed?	pric dea	r to con th?	npletion of ca	iuse of
a F	sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner?		-	26. Pi	lace of Death	1 □ Ye: h (Check only one)	s 2 X N	No 1 L	Yes	2 L.I No	
Ξ	hysicia his cert	၉	1 ☐ Yes 2 🛣 No	lospital: 1 🛂 Inpatient 2 🗌		t 3 🗆 DOA Oth	er: 4 🗆 Nui	rsing Home 5 🗆 Re	sidence	6 Other (Specify)		
n of	tending Ph leath. or: After th the funeral	Certificate:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	⟨?	28d. Describe	how inju	iry occurred			
siol	Attendier death. ector: Ai	ıţįį	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me. farm. stre		Yes 2 🗌	No 28f. Location	(Street a	nd Number o	r Rum I I	Poute Numbe	ar.
Division of Vital	al or safte		4 ☐ Homicide determined	building, etc. (Specify,)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, State		, marari	Todio Mannoo	" ,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in E	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	cian: To the best of my knowler: On the basis of examination	edge, death o	ccurred at the time	e, date and p	place, and due to the	cause(s)	and manner	as state	d. se(s) and mon	ner stated
	the lithin 2 the formula the f	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of m	ny knowledge,	death occurred at t	the time, date	e and place, and due to	the caus	se(s) and man	ner as st	ated.	stateu.
	0 / F = F		Parameter and the or sortino	11.1		D65				ate signed (N		ay, Year) - 20	1.0
			30. Name and address of person who con Farzad Malekan tar	empleted cause of death firem	2 3a) (Ty pe, P					0	17		10
						Gren Ro	ad, S	liver Spri	ng,	MD 209	110		
	Stat Registra	_	31. Date filed <i>(Month, Day, Year)</i> AUG 1 6 201	32 Registrar's Signat	h ha	New .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2.0 1.2

			For State Registrar	e of Marylan	a / Depa <i>Cer</i>	irtment of H tificate of D	ealth and leath		giene 2 () Reg. No.	12 282/6
	Physicia	in/	Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
	Medi Examir		Edwin Leroy Mart 4a. Facility Name (if not institution, give street and	number)	_	4h City Town and	Landing of Door	Aligus		
	Examili	iei	Meritus Medical Cente			4b. City, Town, or Hagerst			4c. County of Washin	
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ıst birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	O. Date of Dirt	1 9	. Birthplace (State or Foreign
h	Director		220-46-7649 1 ₺ M 2 □	65	Yrs.	World S Days	Hours I Will.	(Month, Day		Maryland
	and show	ō		10c. City	, Town or Loc	ation				10d. Inside City Limits
	Maryla 28a-f ptifiec	Director	MD Washington	Hag	erstow	n				1 ☐ Yes 2 🗓 No
	h the	a D	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	ith wit ms 23 must	Funeral	19 Brightwood Drive			21740			U.S.	Α.
21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S d Forces? Yes 2 X I No , Give or Dates.		/as Decedent of His Yes, specify Cuban ☐ Yes 2 【 No		pecify Yes or No- p Rican, etc.)	Black, V	American Indlan, White, etc. White
15-1	72 hoi n "nat ledica	Jple	15. Decedent's Education (Specify only highest grade comple	eted)	(Give ki	ent's Usual Occupat ind of work done du	tion uring most of wor	king	16b. Kind of Busin	•
212	vithin iene. r thar the N	Con	Elementary/Secondary (0-12) Colleg	ge (1-4 or 5+)		NOT use retired) al Direct	or		Maryland Correc	Dept. of
פר	al Hyg I othe vent,	Be	17. Father's Name (First, Middle, Last)			- 1	18. Mother's Nar	ne (First, Middle, N		LIONS
ylaı	ld be Menta arked atic e	오	Paul Martin				Kathe	rine Clu	re	
Maryland	shou h and 7 is m raum	a ž	19a. Informant's Name/Relationship (Type, Print)						City or Town, State	, Zip Code)
ė,	and 2 Healt tem 2	1	Anne R. Martin/Wife 20a. Method of Disposition	20h Bi		rightwood	Drive,			21740
Baltimore,	age 1 ent of nt: If ii		1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State Ce	metery, crema	atory or other place; g Cremato	8/25	1	20c. Location - Cit	
a	mit. F partm portai y injur		21. Signature of Funeral Service Licenses	- SIIII					Smithsb Funeral	urg, MD
מ	8 5 5 5	W. J		b	10	601 Penns	ylvania	Ave., Ha	agerstown	
4	Prysician/		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition			the mode of dying,			st,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due	to (or as a conseque	ence of):					
	DE B	ner	Sequentially list conditions, b.	Aspirat		cute				approx2hrs
	uted Id ansit	ami	cause. Enter Underlying Cause (Disease or injury that initiated events c.		•	a of Es	ophagu	S		
	e exection articles of the control o	E E	resulting in death) Last Due	to (or as a conseque				· · · · · · · · · · · · · · · · · · ·		
9	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	d							
0	certific nding use as	Ň	IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnance	су					
200	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/N	in the past 12 months?	ive Birth 2 🔲 Fetal Pregnant at time of de Inknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
5	es that the dea signed by the a be detached t		Part II. Other significant conditions contributing to		Iting in the un	derlying cause giver	n in Part I	220 Did tob	anne une contribut	e to the cause of death?
<u>ה</u>	ires the signer of signer of the signer of t	od by			3	,g g,		1 ☐ Ye		Probably 4 Unknown
cords,	w requires s been sig	Bete						24a. Was an		autopsy findings available
ט ב	The law ate has page 2	Completed						autops perform	y prior death	to completion of cause of
9	ysician: The nis certificate I director, pag		25. Was case referred to medical examiner?	_		26. Place	e of Death (Chec	1 ∐ Yes 2 k only one)	NO I	Yes 2 □ No
>	Physic this c	욘		☐ Inpatient 2 ☐ E				ome 5 Reside	nce 6 Other (Sp	pecify)
=	ding Phy th. After thi funeral	Certificate:	1 Natural 5 ☐ Pending	ate of injury 2 fonth, Day, Year)	8b. Time of injury	28c. Injury a work?		28d. Describe how	w injury occurred	
	al or Attending s after death. I Director: Afte d in by the fun	Ě	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ace of Injury - At hom	ie, farm, stree		s 2 No	28f. Location (Str	eet and Number or	Rural Route Number.
2	tal or rs afte al Dir	_	addininied bu	ilding, etc. (Specify)		•	Į.	City or Town,		, rara, riodic ramper,
:	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by the	Med	29a. Certifier (Check only one) 1 Certifying Physician: To the only one) 3 Certifying Nurse Practitio	dasis of examination a	and/or investia	ation, in my opinion, eath occurred at the	time, date and pl	t the time date and	nlace and due to the	no causeo(s) and mannor stated
1	0 W i 0		29b. Signature and title of certifier			29c. License ni		29	d. Date signed (Mo	enth, Day, Year)
	021			my the	10	D170:	27		08/24/20	012
	5		30. Name and address of person who completed c. Wun B. Kang, M.D.				., Hage	erstown	, Md 217	740
	State Registra	r	31. Date filed (Month, Day, Year)	. Registrar's Signatur		all de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg No 2 0 2 2827
			1. Decedent's Name (First Middle Last)
	Physicia Medi		Arnold Eugene MARTIN, Sr. 2. Date of Death Annold Eugene MARTIN, Sr. 3. Time of Death August Day 2 2012 /300M
-	Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			Meritus Medical Center Hagerstown Washington 5. Social Security Number 6. Sex 7. App (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Data of Birth
В	Funeral Director		212 = 30 = 0.003
	wo		Usual Residence of Decedent Nov. 27 1932 Maryland
	ryland r-f shr ied at	ctol	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	or 28a	Director	Maryland Washington Williamsport 1 □ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	with th	Funeral	109.02 Domo 1 com Desires
	leath items er mu	Fu	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
36	after o	þ	1 IX Yes 2 No
21215-0036	atura cal Ex	Completed	15 Decedent's Education 150 Decedent
215	n 72 h an "n Medi	Id m	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Genetic for only highest grade completed) 16b. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16b. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16b. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only file. DO NOT use retired) 16c. Kind of Business/Industry (Bernard for only fil
2	withi	ပိ	12 0 Floor Sander Self-Employed
Maryland	e filec tal H ed otl	To B	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ž	ould b		Clement Martin Janie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Alumba and Print) 19b. Mailing Address (Street and Alumba and Print)
∑	d 2 shoalth an 27 is r trau		130. Mailing Address (Street and Number of Rufal Route Number, City of Town, State, Zip Code)
ore,	1 and of Head		20a. Method of Disposition 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of 20b. Place of Disposition
im	ment ant l		1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 8/27/2012 Hagerstown, Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home
	EU = 60	_111	415 E. Wilson Blvd. Hagerstown, Maryland 21740
Ŋ,	SECURITION 1		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
	Physician Medical	1	Immediate cause (Final disease or condition resulting in death) ANOYIC ENCEPTIAL OF A PROPERTY OF A
	Examiner		Immediate Cause (Final disease or condition resulting in death) ANOYIC ENCEPTATORATY Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):
	n #	Examiner	cause. Enter Underlying
	ecuted and I-trans	xan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
0	death certificate be executed re attending physician and ed for use as the burial-transit	dical	Sub-to-(of-da-d-d-of-loc-dof).
3760	ificate g phy as the	Medi	d.
Box 687	ath certifica attending p	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 2
		Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown
P.O.	es that the dee signed by the a I be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S,	uires t n sign uld be	Completed by	ENDSTAGE REWAL DISEASE 1 Yes 2 No 3 Probably 4 Junknown
Ö	w require is been si 2 should 1	plet	24a. Was an 24b. Were autopsy findings available
Records,	sician: The law signers to sertificate has birector, page 2 s	E O	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No
ţa.	ysician: is certific director,		25. Was case referred to medical examiner? 26. Place of Death (Check only one)
<u> </u>	Physi this c	유	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 18c Injury at 18cd Describe how injury accounted.
יים	tending Phys death. tor: After this of the funeral dii	cate	28b. Imme of Joean 28c. Injury at 28d. Describe how injury occurred 28d. Injury at 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Injury at 28d. Describe how injury occurred 28d. Injury at 28d. Describe how injury occurred 28d. Injury at 28d. Describe how injury occurred 28d. Describe how injury occurre
Division of Vital	or Atter after dea Director in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Boute Number)
_ Ω	ital or irs aftr al Dir		City or Town, State)
;	the Hospital or Attending Physician: The law requires that the Linz 4 hours after death. The Funeral Director: After this certificate has been signed by the mpletely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier (Check Check Ch
:	To the Hospital Within 24 hours a To the Funeral C completely filled		colly one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			E. Palmer MD Dirin 69946 8127/2012
	2	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	O,		EMERIC PARMER, MD - 1/16 MEDICAL CAMPUS RD, HAGERS TOUN MD
	State Registra	_	31. Date filed (Month PGYs) 4 2012 32. Registrar's Signature

		Please Type or Print in					_	_	ble.
		1 - State of Marylan		artment of H tificate of D		nd Men	, ,	ene g. No. 20	12 28278
Physicia Media		Decedent's Name (First, Middle, Last) Francis Xavier M	urray			1	Date of Death Month 1gust	Day 16, 20	3. Time of Death 912 6:00 A. M
Examir	ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I				4c. County c	
Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. In the property)	ast birthday)	Silver If Under 1 Year	Sprin If Under 24		Date of Birth		tgomery 9. Birthplace (State or Foreign
Director		206-28-8005 1 ☒ M 2 ☐ F	Yrs.	Months Days	Hours		Month, Day, Y	ear)	Country)
land show dat	ě	101 0	y, Town or Loc	ation			1/07/1	937 .	Pennsylvania 10d. Inside City Limits
Maryl. 28a-f otified	Director		ermant	own					1 ☐ Yes 2 🛣 No
ith the 23a or it be n		10e. Street and Number		10f. Zip Code			10	g. Citizen of Wi	nat Country?
eath w tems 2	Funeral	12120 Sunnyview Drive 11. Marital Status 12. Was Decedent Ever in U.S.	3. 13. V	20876 Vas Decedent of His		1? (Specify Y	es or No-		States - American Indian.
after d	þ	1 ☐ Never Married 2 🛣 Married Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	1	Yes, specify Cuban	, Mexican, P	Puerto Rican	n, etc.)	Black	White, etc.
2 hours after death with the Marylar "natural", or items 23a or 28a-f's edical Examiner must be notified	etec	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education		ent's Usual Occupat				Specify:	White
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k life. DC	ind of work done du NOT use retired)	ring most of			6b. Kind of Bus	
illed wall Hygi	Be	17. Father's Name (First, Middle, Last)	EIIV.	iromental				rederal iden Surname)	Government
uld be Menta narkec	은	Charles Edward Murray	, Sr.			Lo	uise	Grube	ee
2 sho Ith and 27 is r traun	1	19a. Informant's Name/Relationship (Type, Print) Mary T. Murray/Spouse	1	g Address (Street an					
1 and of Hea item	, l	20a. Method of Disposition 20b. Pl	ace of Dispos	sition (Name of		7e, Ge			cyland 20876
Page ment c tant: If				atory or other place) tan Crem.		/17/20	012 A	lexandr	ia, Virginia
permit Depart Impor any in once.	~	21. Somethe of Funeral Service Licensee		Name and Address	of Facility	DeVo1	Funera	al Home	
		23a. Part 1. Enter the disease, or complications that caused the death							g, MD. 20877 Approximate
Physician/		shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition and the death). Acute Respir	atorv	Failure					Interval Between Onset and Death
Medical Examiner		Due to (or as a consequence of the control of the c							
	ner	Sequentially list conditions, if any, leading to immediate b. COPD Due to (or as a consequent or co	ence of):				_		
and and al-transit	Examiner	Cause (Disease or injury that initiated events c.							
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ath ce attend for us	cian/	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 1 Ves	death 3	Ectopic pregnancy Other (specify)				23d. Date	
the de	hysi	1 Yes 2 No 4 Pregnant at time of de 9 Unknown 9 Unknown	saur 5 🗆	Other (specify)				- IVIOITI	T Day Teal
ss that igned be del	by	Part II. Other significant conditions contributing to death but not resu Hypertension, Hyperlipidemia	Iting in the un	derlying cause giver	n in Part I.	2			ute to the cause of death?
requir been s should	leted	hypertension, hyperhipidemia				- 20			Probably 4 🖾 Unknown
he law te has age 2:	omp					- ²	4a. Was an autopsy performed	d? prid	re autopsy findings available or to completion of cause of ath?
cian; T ertifica ector, p		25. Was case referred to medical examiner?		26. Place	e of Death (C	Check only o	Yes 2 2	No 1 L	Yes 2 No
Physic this c	은	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ E 27. Manner of Death 28a. Date of injury 2	R/Outpatient					e 6 🗆 Other (Specify)
anding ath. r: After	icate	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ AccidentInvestigation	injury	28c. Injury a work? M 1 \square Ye	t es 2□No	- 1	escribe how i	njury occurred	
l or Atter after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Lc	ocation (Stree ity or Town, S	t and Number o	or Rural Route Number,
To the Hospital or Attending Physician; The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burrian	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	and/or investic	ation, in my opinion.	death occurr	red at the tim	ne date and n	lace and due to	the cause(s) and manner stated
To the within 2 To the comple	Σ .	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my 29b. Signature and title of certifier	y knowledge, o	leath occurred at the 29c. License no	time, date ar	nd place, and	d due to the ca	ause(s) and man	ner as stated. #onth, Day, Year)
20		▶ Yegus	se,	D 6	9288				6, 2012
	- 1	30. Name and address of person who completed cause of death (Item 2 Yodit Negusse, M.D., 1500 Forest	, , , , ,	nt)		nrina			
State	е	31 Date filed (Month Day Year)			VET D	hrring	, mary.	Lanu 20).TO
Registra	r	AUG 20 2012 Sentra S.	gar	1					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Maria Guadalupe Medrano 10:27 PM 14, 2012 Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8531 11th Avenue Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 579-72-5157 **Director** San Rafael Oriente, El Salvador 1 🗆 M 2 🔀 F 70 Yrs February 9, 1942 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8531 11th Avenue 20903 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 🖾 Yes 2 🗆 No Specify: Salvadorian Completed 3 Widowed 4 Divorced Specify: Hispanic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Industry Food Preparation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eustaquio Aparicio Dolores Soto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria G. Medrano / Daughter 12005 Pheasant Run Drive, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Fort Lincoln Cemetery 1 🗵 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 8/20/2012 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Clear Cell Carcinoma of Kidney disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Month Day Year Unknown g Unknown þ signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Yes 2 🛭 No ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No __ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi

Records, P.O. Box 68760 Division of Vital

Baltimore, Maryland 21215-0036

2 371 State Registrar (Check only one)

29b. Signature and title of certifier

Jocetyne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Toukep Kouatchou, M.D., 201 East University Parkway, Baltimore, MD 21218

31. Date filed (Month, Day, Year)
AUG 2 4 2912

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D63742

29d. Date signed (Month, Day, Year)

Z

8

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\overset{\text{Day}}{2}\underline{012}$ Month Alberta B. Moffitt August 8 A^{M} Medical 8:45 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9006 Oxon Hill Road Fort Washington Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months **Director** 579-46-6155 1 □ M 2 🛂 F Usual Residence of Decedent 76 July 13.DC 28a-f show 10b, County be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland | Prince George's 1 X Yes 2 No Fort Washington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral with 9006 Oxon Hill Road must 20744 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S and Mental Hygiene. Is marked other than "natural", or iter raumatic event, the Medical Examiner. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes Give African 3 K Widowed 4 Divorced Completed American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th US Postal Service Supervisor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev should be Harold Walker Mabel Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Robbin I. Brown - Daughter 806 Buckmaster Lane Fort Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Mary Land
National Cemetery 1 X Burial 2 Cremation 3 Removal from State Aug. 14, 4 Donation 5 Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. T- Stewar Letim M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition resulting in death) Hypertensive Cardiovascular Disease Medical Examiner Atrial Fibrillation Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a son sequence of, attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 d. IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 1 | Yes 2 | 9 | Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 X No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ည 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa After this 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending eral Director: A filled in by the fi Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medica 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) Centhra fundreen D27650 August 13, 2012 GAM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Gale Crawford-Green 6196 Oxon Hill Road Oxon Hill, Md. Suite 500 20745 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a.pt I.b., 27, 28a-f, per me, g938 4-9-13 sm
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2ďr^ar2 08:59 а м JAMES MCCASKILL .TR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death SOUTHERN MARYLAND HOSPITAL Prince Georges Clinton Social Security Numbe 7. Age (In vrs. last birthdav If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 267-88-9266 1 🕱 M 2 🗆 F 62 June 26, 1950 MI Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location notified at Director 10d. Inside City Limits 1 Yes 2 X No Temple Hills MD Prince Georges 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a by Funeral be filed within 72 hours after death with 2901 Colebrook Dr. USA 20748 items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 'natural", Specify Completed 3 Widowed 4 Divorced 1971 Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Mover Office Movers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Olga Riley James McCaskill, Sr. t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Staton - Sister 1310 Owens Rd. Oxon Hill, Md 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cem 8-13-2012 Triangle, VA Signature of Euneral Service Licensee Marsharld Marchill Funeral Home of Maryland Suitland Rd. Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician disease or condition resulting in death) Medical Due to (or as a consequence of): Exsanguination **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence on physician and the burial-transit executed CERTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the be detached 9 Unknown a I Inknown To the Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Dislodgement of dialysis shunt death. 1 ☐ Yes 2 X No 2 🔀 Accident Investigation 8-3-12 8:00 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2901 Colebrook Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Temple Hills,MD. within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 09/09/1 D0064055

Registrar
DHMH 17 Rev 06-2011

State

450

Jak.

Clinton, MD

Surratts Rd.

Registrar's Signature

20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503

Eric McDonald, MD

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28282 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Medical Patricia Jean Newman August .2:15 a.nº 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 46868 Flower Drive <u>Lexington Park</u> St. Mary's Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. (Month, Day, Year) Country) Director 056-32-9775 1 M 2 TXF 74 01/16/1938 New York permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hyglene. Importent: If item 27 is merked other then "neturel", or iteme 23e or 28e-f ehoventy Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No St. Mary's Maryland | Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46868 Flower Drive 20653 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Ball Muriel Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew K. Newman/Son 20224 Spitfire Court, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charles Memorial Cem : 08/22/2012 | Leonardtown, MD 21. Signature of Fameral Service Licens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield ĴΫ́. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician neumoura disease or condition resulting in death) Medical Due to (or as a consequence of): [⊀]Examiner betweetine. Pulmona some Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The lew requires that the death certificate be executed caucin attending physicien and for use as the buriel-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day After this certificate has been signed by the a funeral director, pege 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ternion Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Hospital Other: 4 Nursing Home 5 🖾 Residence 6 🗌 Other (Specify) 2- No |은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death Natural 2 \ \rightarrow A 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 24 hours after death. e Funerel Director: Affoletely filled in by the fu work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60888 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, M.D. 26840 Point Lookout Road, Leonardtown, MD 20650

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 2 2012

Registrar's Signaty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Brown Nethers August 4:11 P Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home St. Mary's Charlotte Hall Social Security Number 8. Date of Birth (Month, Day, Year) 06/17/1924 **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Hours Director 229-34-6581 88 V<u>irginia</u> Usual Residence of Decedent show 10a. State 10b County with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 Yes 2 No Virginia Winchester Frederick 10e Street and Number 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 4168 Valley Pike 22602 US Page 1 and 2 should be filed within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Production Line - Block Press Brake Manufacturer Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Clifton Nethers Inez P. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 504 Gazelle Trail, Winchester, Virginia 22603 <u>Tiffany Nethers/granddaughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Jones Funeral Home,Inc 08/21/2012|Winchester, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO174 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) Day Pregnant at time of death signed by the a Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed After this certificate DRONARS 1 ☐ Yes 2 ☐ No Yes . Was case referred to medical examiner? upleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 🔲 Yes 2 No ြို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate; 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

(Check only one 29b. Signat

Stephen P. Cafferty,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MTCHAEL. PATRICK NELSON, SR. 08 PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 8. Date of Birth (Month, Day, Ye MAY 16, 1964 7. Age (In yrs. last birthday) 48 Birthplace (State or Foreign Country) If Under 1 If Under 24 Hrs **Funeral** 577-96-1826 Days Director 1**XX**M 2 □ F WASH., D.C. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Examiner must be notified CHARLES 28a-f WALDORF 1 Yes 2 XXo ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2009 ST. items 23a UNITED STATES THOMAS DRIVE, #123 20602 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 24 Who If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 X Never Married 2 Married Specify: BLACK 1 Yes 2 XX Specify 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
title DO NOT userstired)
CHEF, WAITER 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) RESTAURANT Elementary/Secondary (0-12) College (1-4 or 5+) G.E.D. (GENERAL MANAGER) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KAROLA E. KOESTNER NELSON BERNARD T. NELSON, SR. 19a. Informant's Name/Relationship (Type, Print)
BERNARD T. NELSON, / FATHER 199. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WINNSBORO DR., FORT WASHINGTON, MD 20744 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of AUG. Date 18. RIVERDALE, MD PARK 2012 4 Donation 5 Other (Specify) 21. Signalur of Funeral Service Licen TERRENCE L'ESCHERON FUNERAL SERVICE, 4433 WHITE PLAINS LANE, WHITE PLAINS, JOHNSON PLAINS LANE, WHITE PLAINS, MD E0000M# 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between set and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Res Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to fur as a currisculusing death certificate be executed burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IE EEMALE: use 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 1 Yes 2 No Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 WNO 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manuer of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 / Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death. To the Funeral Director: A the 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day,

State Registrar 31. Date filed (Month. Day

person who completed cause of death (Item 23a) (Type, Print)

Redistrar's Signature

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28285 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21^{Day} Richard Daniel NEWLIN, Sr. 2012 August 15:05 p.™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 533 Guilford Avenue Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Hours Min. July 13, Year) 220-30-9561 77 **Director** Maryland Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Washington Hagerstown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 533 Guilford Avenue within 72 hours after death with 21740 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕱 No <u>\$</u> 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th mill wright furniture mfg. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Marion F. Newlin Anna May Sherman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Newlin - wife 533 Guilford Ave., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔣 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/25/12 Manor Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Tilghmanton, Maryland Signature of Funeral Services 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Small Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death Yes 2 ☐ No Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy this certificate 1 Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2012

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mont

egistrar's Signatu

toperstown, nap 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep	partment of Health and N Prtificate of Death	Mental Hygier	ne No. 2012	28286			
	Dhusisis	-/	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death						
	Physicia Medic	al	HAZEL LEE NEAL		Month /14/2		10:00 P M			
	Examin	er	4a. Facility Name (if not institution, give street and number) 1115 GLACIER AVE.	4b. City, Town, or Location of Death CAPITOL HEIGHTS		4c. County of Death PRINCE GEORGE S				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	9. Birthpla	Birthplace (State or Foreign Country)			
	Director		426–42–0147 Usual Residence of Decedent	Months Days Flours Will.	(Month, Day, Yea) 11/24/192					
	land show dat	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or L	ocation		10	d. Inside City Limits			
	Mary 28a-f		MD PRINCE GEORGE'S CAPITOL				1 X Yes 2 No			
	vith the 23a or st be r		10e. Street and Number 1115 GLACIER AVE.,	10f. Zip Code 20743		Citizen of What Country NITED STATE				
	e filed within 72 hours after death with the Maryland the Hygiene. All they filed of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America				
36			1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No 1 ☐ Yes 2 ▼ No 1 ☐ Yes Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Rican, etc.)	Black, White, et Specify: BLACE				
9	hours natura ical E		Year or Dates. 15. Decedent's Education 16a. Dece	dent's Usual Occupation	166	b. Kind of Business/Indu				
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2	ed with Hygier other t		12th CAFE 17. Father's Name (First, Middle, Last)	TERIA WORKER		PRIVATE				
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lary	should and M is ma aumal		19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or Rura			ode)			
d)	and 2			GLACIER AVE., CAP						
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State MARY CARTON	Market Ranglace)	[Location - City or Tow				
alti	mit. P. partme portar / injur		4 Donation 5 Other (Specify) 21. Signature of Funeral Segrice Licensee	2. Name and Address of Facility PO		HELTENHAM, L HOME, P.A				
ñ	Im Deer any		1 Santi Phil - MO1653	5538 MARLBORO PIK						
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	Physician Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	AHUTLE			Onset and Death			
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			Sequentially list conditions, b. If I any leading to him ediate cause. Enter Underlying							
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6876	tificate ng phy e as th	Med	IF FEMALE:							
Box 6	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Me	In the past 12 months:	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery	y Day Year			
Ö.	the deg	hysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown							
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rds,	law requires la s been sign e 2 should be				1 🗆 Yes	2 No 3 ☐ Proba				
Vital Records,	has has	Completed			24a. Was an autopsy performed	prior to com	y findings available pletion of cause of			
T E	sician: The l certificate h irector, page	Be Co	25. Was case referred to medical	26. Place of Death (Check	1 \(\text{Yes} 2 \(\text{X} \)		□ No			
Ž	hysici his cer Il direc	일	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor		6 Other (Specify)				
Division of	ing Pt	ate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe how inj	jury occurred				
SIO	Attendar deatl	Certificate:	2	M 1 Yes 2 No	28f. Location (Street	and Number or Rural R	oute Number.			
<u>></u>	tal or ins afte al Dire	Medical Ce	building, etc. (Specify)		City or Town, Sta		,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation.	stigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause	e(s) and manner stated.			
		Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	e, death occurred at the time, date and pla 29c. License number	ce, and due to the cau	use(s) and manner as sta Date signed <i>(Month, D</i> a				
			· Muse	HPT 122524051		AHGUST 10	c++ 26.12			
	2Jan		30. Name and address of person who completed cause of death (Item 23a) (Type,	· ·						
DR. CLINT HOANGQUOCGIA 1050 WEST PERIMETER RD., ANDREWS AFB, MD 20762 State Registrar 31. Date filed (Month); Day, Year) 32. Registrar's Signature										
	Registra		AUG 2 7 2012 Down A. 100	user						
	1H 17 Roy 06 2									

State of Maryland / Department of Health and Mental Hygiene 2 1 2 28287 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0443AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 161-52-7522 **Director** 1 M 2 - F 73 05 1939 MEGHANISTAI iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMER 1 Yes 2 No SILVER 10e. Street and Number 10a. Citizen of What Country? Funeral 3703 20906 USA MUNSEY 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE "natural", should be filed within result and Mental Hygiene.
27 is marked other than "natural" 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) VOICE OF AMERICA EDITOR Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ALEF NOOR ZARAY NOOR 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROTHER FREDERKK MD.21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 K Burial 2 Cremation 3 Removal from State FREDERICK MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility IN MUSLIM FUNERALSER 21. Signatur of Funeral Service Licensee HO#1070 OCDBRIDGE 23a. Part 1. Enter the disse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failur Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** phamonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): myelodysplastic and -trar resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ō in the past 12 months? Day Year Pregnant at time of death 2 No ed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🗣 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 🛛 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fi after death Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) August 13, 2017 1,Tm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roduille, 9001 medial center Drive, many lord Smith, MD Juanita 31. Date filed (Mon 32 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28288 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DAVID B. NEAL, SR. **62713/56**75 70:05 V W 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Capitol Heights 5714 Balsam Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 577-11-243A
Usual Residence of Dece 1 🔀 M 2 🗆 F 42 Yrs. 11/12/1969 10a. State 10c. City. Town or Location 10d. Inside City Limits Capitol Heights Prince George's 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? **AZU** 5714 Balsam Street 20743 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc 1 Never Married 2 X Married 1 Yes 2 X No Specify. 3 Divorced Specify: **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Neal Shirley Clemmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia D. Neal / wife 5714 Balsam St., Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗎 Removal from State Chesapeake Crematory 08 15/2012 Beltsville, MD
22. Name and Address of Facility Strickland Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 1 E. Hedgman Man 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sorcoma Metastatil Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause Enter I no dying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner

> and burial-trar

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igned by the at be detached for signed by

page 2

filled in by the funeral director.

completely

29b. Signature and

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANP.

BC

After this certificate

s after death

Hospital within 24 hours a To the Funeral I

Physician/

Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

items

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Examiner

other traumatic event, the Medical

permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event."

Director

Funeral

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Completed

Be

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MD

the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner 2 Completed Be 卢 Certificate:

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day Year				
Certificate: To Be Completed by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.	1 Ves 24a. Was an autopsy	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of			
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	performed \(\) \(No 1 🗆 Yes 2 🗹 No			
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	DOA	Home 5 Residence 28d. Describe how inju				
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	′) 		City or Town, Star				
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								

29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 0330AM Medical 4a Facility Name (if not institution, give street and number of **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury, 69 ma 2180 Wiconico 105 Times Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New Jersey 8. Date of Birth **Funeral** Date of Cay, (Month, Day, Days **X**M 2 □ F Hours Director 217-54-6111 61 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 105 Times Square within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1971 Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. 1972 Specify: Black Completed 3 Widowed 4 K Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Campbell Soup Co., Ind Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Northern Oglesby Annie Marie Cottman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Jones/ Cousin 608 Dawn Court - Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Eastern Shore Veteran's Cem. 8/20/2012 Hurlock, MD 21. Signature Funeral Service Licenses 22. Name and Address of Fasalisbury, Maryland Jolley Memorial Chapel – 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death ASCVD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CVA Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Failure To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lilied in by the funeral director, page 2 should be detached for use as the burial-transit Renal that initiated events resulting in death) Last Due to (or as a consequence of): Insipidus Physician/Medical Diabetes Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗙 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq\) Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

ST. #

504B. Salisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Das

106 Milford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Osterman, Sr. Joseph 201 Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner chad AND NURSING mico p m 7. Age (In yrs. last birthday) Funeral 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Min Director 1 ÅM 2 □ F 214-26-5923 82 May 2, 1930 Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director ems 23a or 28e-f sh r must be notified a 1 ☐ Yes 2 🖾 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 717 South Kaywood Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 1951— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed 3 Divorced 1954 Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Importent: If item 27 is marked other than any Injury or other treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 District Sales Manager Gas Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health end Mental I မ Osterman Kathryn Muth George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 717 South Kaywood Dr. Salisbury, MD 21804 Joanne L. Osterman- Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 8/17/2012 Delmar, Delaware 4 Donation 5 Other (Specify) 21. Signature of Juperal Service License 22. Name and Address of Facility Bounds Funeral Home 23a. Par/l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21804 Approximate Interval Between Onserand Death Physician/ disease or condition resulting in death) CAVE Medical Due to (or as a consequence of). Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use es the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be

Division of Vital Records, To the Hospitel or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors.

State

Medical

29b. Signature and ti

determined

4 Homicide

29a. Certifier

(Check

only one)

29c. License number

🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

s of person who completed cause of death (Item 23a) (Type, Print)

Dorodulia

31. Date filed (Month, Day, Year) 32, 15

Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		artment of F tificate of L		d Mental Hy	giene Reg. No.2	012	28291
	Physicia	ın/	1. Decedent's Name (First, Middle, Las Anthony Joseph	o†Tousa				2. Date of De	ath Day	Voor	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of De			2012 Dunty of Death	1:25 am
أمدينه			Necitas Assisted	Living			r Spring		ı	Montgom	ery
	Funeral Director		5. Social Security Number 204–16–3181 6. S Usual Residence of Decedent	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year)	9. Birthr Coun PA	
	show	ō	10a. State 10b. County	10c. (City, Town or Lo	cation				1	0d. Inside City Limits
	Mary	irec		omery	Gaithe	rsburg					1 🗆 Yes 2 🖾 No
	h with the ns 23a or must be n	Funeral Director	10e. Street and Number 217 High Timber			10f. Zip Code 20	879		_	n of What Cour USA	ntry?
9036	1 end 2 should be filed within 72 hours after death with the Marylend if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination ust be notified at	至	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Amped Forces? 1 ☑ Yes 2 ☐ No U If Yes, Give Year or Dates.	nk I	Was Decedent of H f Yes, specify Cuba	ın, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		. Race - Americ Black, White, o White ecify:	
5	72 hor	Completed	15. Decedent's E (Specify only highest gr	ade completed)	I (Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of w	vorking	16b. Kind	of Business/Inc	dustry
212	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		rensic S	cientis	t	Fede	ral Gov	ernment
Maryland 21215-0036	should be filed or and Mental Hyg 7 is marked other raumatic event,	To Be	17. Father's Name (First, Middle, Last) Joseph 0 Tousa					lame (First, Middle, cy Tumine		name)	
, Man	end 2 shoul Health and I tem 27 is mi		19a. Informant's Name/Relationship (7) Brian J. O'Tousa/		19b. Mailin 1110	ng Address (Street a	Road,	Rural Route Numbe Silver Sp	r, City or To	wn, State, Zip C MD 209	Code) 03
Baltimore,	permit. Page 1 er Department of H important: If Itel any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Dispo cemetery, cren tropoli	sition (Name of natory or other place tan Crema	e) tory A	ug ₀₁₂ 15,		tion - City or To andria,	
Ball	permit Depart import any inj once,		21. Signature of Funeral Service Licens		Fr 50	Name and Address J. O Univers	ss of Facility Collins Sity Bly	s Funeral	Home ilver	Inc. Spr i ng,	MD 20901
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that caused the de ne cause on each line.							Approximate Interval Between
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Due to (or as a conse		e Cancer					Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b. ————————————————————————————————————							
	Usit &	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
	ficate be executed g physician and as the burlal-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
760	cate b physi s the b	ledic		d							
P.O. Box 68	death certi ne attendin ed for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ For 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnance Other (specify)	ey .		230	d. Date of delive Month	ery Day Year
Ö	ed by detac	y Ph	Part II. Other significant conditions of	ontributing to death but not r	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to th	e cause of death?
ds,	law requires that the nas been signed by tt e 2 should be detach	ted by						_ 1□	Yes 2 □ I	No 3 ☐ Prob	oably 4 DXUnknown
8	The law re zate has be page 2 sh	Completed						24a. Was auto perfo 1 Yes	osy rmed?	4b. Were autor prior to cor death? 1 ☐ Yes	osy findings available mpletion of cause of
ā	icien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Pl	ace of Death (CI	heck only one)		Assist	ed Living
<u>></u>	y Phys er this eral dii	e: 10	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	t 3 DOA Othe	4 ∐ Nursing	Home 5 Resid		Other (Specify)	or profits
ro io	ttending death. tor: Afte the fun	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		injury	M 1 🗆	? Yes 2 ☐ No				
DIVIS	Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			28f. Location (S City or Tox	m, State)		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	only one) 3 Certifying Nurs	sician: To the best of my kno iner: On the basis of examinat se Practitioner: To the best o	tion and/or invest	igation, in my opinio death occurred at t	n, death occurre he time, date and	d at the time, date a d place, and due to t	nd place, and he cause(s) a	d due to the cau and manner as s	se(s) and manner stated. tated.
	Ogen		29b. Signature and title of certifier	Nayer		29c. License D17	e number 1874			gned (Month, E 15, 20	
_			30. Name and address of person who of Sankaran M. Naya:	completed cause of death (Ite	em 23a) (Type, P 7 38th	nnt) Avenue, (Cottage	City, MD	20722	2	
	Stat Registra		31. Date filed (Month, Day, Year) AUG 16 2012	62. Registrar's Sign	pature face	20.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28292 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Month Mildred Vannatta Obimbo 15 6:20 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House-Montgomery Hospice Derwood Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Numb **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 088-24-5138 July 12, Director 1 M 2 T F 1933 79 New York Usual Residence of Decedent in then "neturel", or items 23e or 28e-f show the Medical Evaminer must be notified at 10a, State 10b. County 10c. City, Town or Location irector 10d. Inside City Limits Maryland Montgomery Clarksburg 1 🗆 Yes 2 🔀 No 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12325 Houser Drive 20871 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 within 72 hours efter 1 ☐ Yes 2 K No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tai Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Law Be 17. Father's Name (First, Middle, Last) .. Pege 1 end 2 should be filed tment of Health and Mental H tent: If Item 27 is merked ot 18. Mother's Name (First, Middle, Maiden Surname) Doyle Vannatta Lillian Mallory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Johnson (Daughter) 12325 Houser Drive, Clarksburg, MD 20871 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Depertment of H Importent: If Its eny Injury or of once. Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Metropolitan 16, 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Crematory ature of Funeral Saw e Licens Sign 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 Infer the dis shoot of heart failu Immediate Cause (Final Interval Between Onset and Death Physician/ Arterial Thrombosis of Right Lower Extremity disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Duvitu (ur as a nonsequence of) ed by the ettending physicien end deteched for use es the buring transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Parkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No director. 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🖾 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSDICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗆 No

or Attending Physicien: The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospitel or Attending Phy within 24 hours effer deeth.

To the Funeral Director: After this completely filled in by the funerel (

6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

D37142

August 15, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

AUG 16

Geoffrey Coleman, M.D., 6001 Muncaster Mill Rd., Derwood, MD 20855 31. Date filed (Month, Day, Year)

State Registrar

Medical

3 Suicide

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28293 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 William 12 Ε, Onianwah 0:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1**X** M 2 □ F **Director** 579-80-6224 8-16-1949 Nigeria 62 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be by Funeral 23a 4326 Canada Hills Ct 20602 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. ral", or iter Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give "natural", Specify: 3 Widowed 4 Divorced Completed Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. d other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed 12 Limo. Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Felix Rebecca traumatic Onianwah Adiqwe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 i 4326 Canada Hills Ct.Waldorf Maryland 20602 Delores Onianwah-Wife injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 s 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 9-1-12 .Peters Cem Waldorf,Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year Day 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Dulmonary Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th Certificate: 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

Registrar

Box 68760

P.O.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1tol-

egistrar's Signature

2 hans

8-13-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Year Joseph William O'Leary 2:40 15, Рм August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4801 Longfellow Street Prince George's Riverdale Park Social Security Number 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min Months 577-16-5610 Hours Director 1 X M 2 □ F 92 August 9, 1920 Pittsburgh, PA Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Riverdale Park Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 USA 4801 Longfellow Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ X Yes 1 Never Married 2 Married 72 hours after 21215-0036 1 Yes 2 X No Specify: Year or Dates. WWII Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Home Improvement $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4 or 5+) Business Owner and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other treesany injury or other treesangerea Thomas Raymond O'Leary Mildred A. Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 Stewart Court, College Park, MD 20740 Michael Joseph O'Leary / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State Brentwood, Maryland 8/21/2012 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Years Immediate Cause (Final Multiple Myeloma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atfet death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe Yes 2 X No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🛛 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending Accident 1 Yes 2 🗀 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier D26287 8/16/2012

Registrar
DHMH 17 Rev 06-2011

State

Michael J. Berard, M.D., 7305 Baltimore Blvd., #107, College Park, MD 20740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 2

		•	for State Registrar	State of N	Cei	rtificate of D		Rentai mygi	ene 20	12	28295
	Physicia	n/	1. Decedent's Name (First, Mic		D 1			2. Date of Death Month		Year	3. Time of Death
· .	Medic	al	Angela 4a. Facility Name (if not institute)	Clare	Palmer	di Oita Taura	Leading of Death	August	7, 20	12	9:30 A M
-	Examin	er	Knollwood M			4b. City, Town, or Mill	ersville	1	4c. County		de1
	Funeral		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		g. Birthpl	ace (State or Foreign
E	Director		218-76-5120	1 □ M 2 🕱 F	70 Yrs.	IVIOITINS Days	nours IVIIII.	(Month, Day, 12/06/1		Countr	ryland
	ind show at	or	Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or Lo	cation		12/00/1	741		Od. Inside City Limits
	Maryla Ba-f s tified	rect	Maryland St	. Mary's	Leonard	ltown					1 🗆 Yes 2 🕱 No
	a or 2 be no	ΙD	10e. Street and Number			10f. Zip Code		10	Og. Citizen of W	/hat Count	ry?
	th with ms 23 must	Funeral Director		Lane Court #1		206			U :	5 A	
(0	or iter	by Fu	11. Marital Status 1 X Never Married 2 □ N	12. Was Decedent Armed Forces Varried 1 Yes 2	?	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America k, White, et	
036	ırs afte ıral", I Exar		3 Widowed 4 Divor	If Von Cive		1 ☐ Yes 2 🗷 No	Specify:		Specify:	Whi	te
5-0	2 hou "natu edica	plet		edent's Education ighest grade completed)	16a. Deced	dent's Usual Occupa kind of work done do	ation uring most of wor	king	6b. Kind of Bu	siness/Indi	ustry
21215-0036	ithin 7 ene. r than	Completed	Elementary/Secondary (0-1	2) College (1-4 or	D+)	O NOT use retired) Disabled			Dis	ab1ed	1
d 2	iled w Il Hygi I othe	Be	17. Father's Name (First, Middle	le, Last)		DIBUDICU	18. Mother's Nan	ne (First, Middle, Ma			
ylar	ld be l Menta arked	은	Columbus	W. Palmer			Mary	Alice	Drury		
Maryland	d 2 should katth and Me 27 is mark r traumatic		19a. Informant's Name/Relation			ng Address (Street a					*
	and 2 Healt tem 2		Deborah L. St 20a. Method of Disposition	. Clair/Siste	20b. Place of Dispo	7 Crab Po	t Lane,		Oc. Location		
ω E	Page 1 lent of nt: If i		1 🔀 Burial 2 □ Cremati 4 □ Donation 5 □ Othe	ion 3 Removal from State	e cemetery, cren	natory or other place loysius		4/2012	Leonar	,	,
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ce /icer kee		Name and Address Mattingle 41590 Fen					
			23a. Part 1. Enter the disease	o complications that cause	ed the death. Do not ente						Approximate
	Ph_sician/		Immediate Cause (Final	st only one cause on each lin	ne.		ientin	, ,	•		Interval Between nset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as	s a consequence of):	(0.1)				- 04	4
	Examiner	Ē.	Sequentially list conditions,	b							-
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequence of):					9	
			that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
00	cate be executed physician and s the burial-transit	lical		d							
387	death certificate be executed ne attending physician and ed for use as the burial-transi	Physician/Medical	IF FEMALE:	00-15					$\overline{}$		
Box 68760	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mon	of deliver	y Day Year
Ö.	the de by the ached	hysi	1 Yes 2 No 9 Unknown	9 🗌 Unknown							
P.O.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant cond	litions contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contril	oute to the	cause of death?
Records,	equire een si	Completed						1 🗆 Yes	2 No	3 Proba	ably 4 🗆 Unknown
900	3 10 01	ğ						24a. Was an autopsy	l pi	ere autops ior to comeath?	sy findings available pletion of cause of
Ĕ	sician: The lav certificate has lirector, page 2		25. Was case referred to medic	nal I		OC DI-	f Dth (0h	perform 1 \sum Yes 2	No 1	Yes 2	. 🗆 No
Vital	ysician: is certific director,	To Be	examiner? 1 Yes 2 No	Hospital:	tient 2 🗆 ER/Outpatier	Other	ce of Death (Chec	ome 5 Residen	ca 6 🗆 Other	(Specify)	
o	ng Phy fter thi nneral		27. Manner of Death 1 D Natural 5 Per	28a. Date of inju	ury 28b. Time of	28c. Injury work?	at	28d. Describe how			
<u>o</u>	tending Path. for: After the funer	Certificate:	2 Accident Inve	estigation		M 1□1	res 2□No				
Division of	al or At s after of I Direct ed in by			armined 28e. Place of Inj	jury - At home, farm, stre tc. <i>(Specify)</i>	et, factory, office		28f. Location (Stre City or Town,		or Rural R	oute Number,
	the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,	Medical	(Check 2 Medica	ring Physician: To the best of	examination and/or invest	igation, in my opinior	n, death occurred a	t the time, date and	place, and due	to the caus	e(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 L Certification Certification 29b. Signature at Certification 20b. Signature 20b. Si	ing Jurse Practitioner: To the	ne oest of my knowledge,	death occurred at the			cause(s) and ma d. Date signed		
			1 /dy 1	Mrm		\$3.	2006	o	811	14/3	012
en	e l		30. Name and address of person	of who completed cause of o	dean (Item 23a) (Type, P	rint)	121 X. I	· Mino	CD. 1	~~	21,10
יישו	Stat	e	31. Date filed (Month, Day, Year		rar's Signature	- de	אטעיץ אין אין	s how	- WUH	170	4/617
	Pagietra		Alic 9	1 2012	. 1 60	No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Benjamin Poole	State of Maryland / Departr 1- For State Certific	ment of Health and Mental I cate of Death	2012 20290
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)		Reg. No. 2. Date of Death Month Day August 23, 2012 Reg. No. 3. Time of Death 1056 hrs
and d	Benjamin Thomas Poole 4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Dea Prince Frederick	th 4c. County of Death Calvert
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24H Months Days Hours M	1
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Maryland Calvert Che 10e. Street and Number	sapeake Beach	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	, ion is the believe	10f. Zip Code 20732	10g. Citizen of What Country? United States
iter death wi ", or items er must be	3 Widowed A Divorced lift Yes Give Year	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No specify:	
2 3 3 6		a. Decedent's Usual Occupation (Give kind on during most of working life. DO NOT use re Manager	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical To Be Comple	Eugene E. Poole	18.Mother's Nam	ne (First, Middle, Maiden Surname) Bergert
— 2 2 8 8	Lucy B. Poole / Mother		Rural Route Number, City or Town, State, Zip Code) lamstown, Maryland 21710 Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite	1 X Burial 2 Cremation 3 Removal from State creme 4 Donation 5 Other Specify: Mt. (atory or other place) And Slivet Cemetery 3	ugust 0, 2012 Frederick, Maryland
	21. Senatur of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do	1621 Opossumtown 1	auffer Funeral Homes, P.A. Pike Frederick, Maryland 21702 or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical Examiner	failure. List only one cause on each line.	plicated by Cirrhosis	Between Onset and
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):		
be execution and inial - tra	■ MENDED AMENDED 23a,pt.II,	27,28a-f,per me,g931	9-20-12 sm
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 4 Pregnant at time of death	y 2 Fetal death 3 Ectopic pregr 5 Other (Specify)	23d. Date of delivery nancy Month Day Year
i, P.O. Be ires that the designed by the it be detached if the deadched if the deby the idea by Physical by Physical by Physical by Physical idea in the interpretation in the i	Chast Injuries	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Cords law requing the been to be should the been to be should the been to be should the been the been the been the been the better the beat the bea			24a. Was an autopsy performed? 1 ✓ Yes 2 No
F Vital Rec Physician: The ar this certificate ral director, page To Be Cor	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	26.Place of Death (Check Outpatient 3 DOA Other 1 Nurs	
Vision of Vortending Physical Control of Attending Physical Control of Physical Control of True of Tru	1 Natural 5 Pending (Month, Day,Year) 2 X Accident Investigation fd 8-23-12 fd	28c. Injury at Work? d 9:56 sm	28d. Describe how injury occurred subject fell
Division o Biopital or Attending 24 hours after death. Funeral Director: After etely filled in by the funeral Director: After etely filled in by the funeral Director and Certification:	4 Homicide determined (Specify) residenc		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4025 15th St. Chesapeake Beach, MD.
To the Hospital within 24 hours. To the Funeral completely filled	Check only one) 2 Medical Examiner: On the best of my knowledge, do one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier		
	30. Name and address of parson who completed assiss of double (flow 23s)	O.C.M.E.	August 24, 2012
0	Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	er 900 W. Baltimore Street, Balti	more, MD 21223
State Registra		1. parks	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10800 M Emma June Price Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Meritus Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 175-22-3347 **Director** 1 □ M 2XX 82 June 1,1930 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland at **Funeral Director** notified Maryland Washington Hancock 1**XX**∕es 2 □ No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe 23a USA permit. Page 1 and 2 should be filed within 72 hours after death with 21750 must & 26 Sable Run Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Examiner Black, White, etc "natural", or þ 1 Never Married XX Married 1 Yes 2X If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Housewife 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Drummer Catherine Frank Jerin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hancock, MD 21750 26 Sable Run Road Floyd J. Price - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 08-25-2012 Williamsport, Maryland Greenlawn Mem. Park 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Sign neral Williamsport,MD 21795 425 S.Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_{sician/} disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) P in the past 12 months? Month Day Year Pregnant at time of death the a Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 🔁 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No 1 🗌 Yes 2 🖳 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 2 Mo 1 Nonpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending s after death. 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) g 4 Homicide determined filled in within 24 hours a To the Funeral Completely filled Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. 2

Registrar

DHMH 17 Rev 06-2011

State

Court

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

2230 PARK, CHUNG AUGUST 16,2012 Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or								_		_	ible.	
		For State		State	of Ma	arylan					and N	lental Hy	/gien	e 2 O	12	28298
		Registrar 1. Decedent's Name	o /First Middle	/ ant)			Cer	tificate	of L	Death	_	0.0	Reg. N	<u>.</u> 2 U	1 4	
Physicia		Chung So										2. Date of De Month August		ay 16	Year 2012	3. Time of Death 10:30 P ^M
Medic Examin		4a. Facility Name (if			nber)			4b. City,	Town, or	Location of	of Death	August		c. County		10.30 F
				ventist H						/ille				Mo	ntgo	
Funeral Director		5. Social Security No. 350-32-0		6. Sex	7. Age		ist birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth a <i>y</i> , Ye <i>ar)</i>		Birthp Count	lace (State or Foreign try)
		Usual Residence of	of Decedent	I LIVI Z LAS F			4 Yrs.					Oct. 2	28, 1	1927	Ko	orea
ryland -f sho ied at	ctor	10a. State	10b. County				, Town or Lo								1	0d. Inside City Limits
ne Ma or 28a notif	Dire	Maryland 10e, Street and Nun		omery	_	(Gaithe:	rsbur 10f. Zip					10a C	itizen of \	Vhat Coun	1 Yes 2 X No
with the 23a can ust be	Funeral Director	150 Chevy	Chase	Street U	nit	204			208	378			rog. c	U.S		ay.
death items ner m	Fun	11. Marital Status		12. Was Dec	edent E		3. 13. V	Vas Deced			gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Rac	e - America	
after al", or xamil	d by	1 X Never Marri		ried 1 Tes If Yes, Gir	2 X	No	- 1	☐ Yes 2							k, White, e	
hours natura lical E	Completed		15. Decede	nt's Education			16a. Deced						16b.	Kind of Bu	ısiness/Inc	dustry
nin 72 ne. shan " e Mec	omp	(Spe Elementary/Seco		est grade completed College (1	-4 or 5		life. Do	O NOT use	retired)	during most	t of worki	ng				
ed witl Hygier other i	Be C	17. Father's Name (F	First Middle I	ast)	5.	+	Pa	atho1	ogis 		or'o Nom	e (First, Middle	Maidan		ical	
be file ental rked c	2	Young Ha								18. Mothe		ing Soo)	
should and M is mar		19a. Informant's Na		nip (Type, Print)			19b. Mailin	g Address	(Street a	and Numbe		i Route Numb			tate, Zip C	ode)
ind 2 s lealth im 27		Sung Won		Brother						lizab	eth	Drive,	01n	ey, 1	1D 20	832
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			X Cremation	3 🕅 Removal from	State	Ce	lace of Dispo emetery, cren	natory or ot	her plac			Date			City or To	
nit. Pa artme ortani injury		4 Donation 21. Signature of Fur	· ·			Met	ropoli			ss of Facility)/2012 DeVol F				VA
permir Depar Impor any ir		Risa	m 7	no mille	an	MO12										D 20877
		23a. Part 1. Enter the shock, or hear	he disease, or t failure. List o	complications that	caused ach line	the death	n. Do not ente	r the mode	of dying	g, such as	cardiac d	or respiratory a	rrest,			Approximate Interval Between
Physician Medical	f	Immediate Cause (I disease or conditio resulting in death)		a. Me	tas	tat	ic	aden	v ca	rcin	omo				1	Onset and Death Omonths
Examiner		rodating in doubly	j	Due to	(or as a	consequ	ence of):									
	iner	Sequentially list cou if an , leading to im cause. Enter Under	mediate 🦼	b. Due to	or as a	consequ	ence of									
executed an and	Examiner	Cause (Disease or i that initiated events	injury S	c	,											
e E	I= I	resulting in death) L	_ast		(or as a	ı consequ	ence or):									
icate I g phys	Physician/Medica			d												
ending	an/∖	IF FEMALE: 23b. Was decedent		23c. If yes, ou			ncy I death 3 🗔	Ectopic p	regnanc	v				23d. Dat	e of delive	ry
e decti the the	ysici	in the past 12 n 1 Yes 2 9 Unknown			nant at	time of d		Other (sp		,				Moi	nth	Day Year
hat the ed by detac	by Ph	Part II. Other signifi	icant condition	ins contributing to c	leath bi	ut not resu	ulting in the u	nderlying c	ause giv	en in Part I		23e. Did 1	tobacco	use contr	bute to the	e cause of death?
uires t n sign uld be	q pa	right	pleur	nl effus	ion							1 🗆	Yes 2	⊠ No	3 🗌 Prob	ably 4 🗆 Unknown
aw red as bee 2 sho	Completed	ph.	eumon	ia								24a. Was				psy findings available appletion of cause of
The la	Con	<u> </u>											ormed?		eath?	_
'sician: The law r s certificate has b director, page 2 s	Be c	25. Was case referre examiner? 1 ☐ Yes 2 Ď	ed to medical •No	Hospital:					Othe	ace of Deat						
g Physer this	e: To	27. Manner of Death	1	28a. Date	of injur	у	ER/Outpatien 28b. Time of		Bc. Injury	4 ∐ Nu rat		me 5 🗌 Resi 28d. Describe				
eath. or: Aft the fur	ificat	1 Matural 2 ☐ Accident 3 ☐ Suicide	5 Pendin Investig 6 Could	gation	th, Day	, rear)	injury	М	work'	Yes 2 🗆	No					
or Att after d Direct in by	Certificate:	4 Homicide	determ	ined 28e. Place		ry - At hor (Specify)	me, farm, stre	et, factory,	office			28f. Location (City or To			r or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the triending physici completely filled in by the funeral director, page 2 should be detached for use as the bit.		29a. Certifier 1	Certifying	Physician: To the b	est of r	my knowle	edge, death o	ccurred at	the time	, date and	place, ar	nd due to the c	ause(s) a	and mann	er as state	d.
the Ho nin 24 the Fu npletel	Medical	only one 3	Certifying	xaminer; On the bas Nurse Practitioner	is of ex	amination best of m	and/or invest y knowledge,	igation, in m death occu	ny opinio rred at th	n, death oc ne time, dat	curred at e and pla	the time, date ce, and due to	and place the caus	e, and due e(s) and m	to the cau anner as si	se(s) and manner stated tated.
		29b. Signature and t	title of certifier	X HADA	0 -		MA	29c.	License	number	2		29d. Da	ate signed	(Month, E	ay, Year)
12		30. Name and addre	ess of person	who completed only	e of do	ath (lem	23a) (Tupo 🗅	rint) -	0	U360			/14	7-(0)	110	
		Barry J	. 1/ 1	n, MD	102	15 1	Cern u	ood	Rd	l- Be	thes	da, M	lory 1	ion d	/	
Stat		31. Date filed (Month	1, Day, Year) 2020	32. R	egistra	r's Signatu	are fact	1								
Registra		NUU	4 4 0 4	16 Herry		10.		4								

			For State	State of Ma	arylan	d / Depa	artment <i>tificate</i>	of F	lealth and Death	d Mental F			2	2829	9
	D 1		Registrar 1. Decedent's Name (First, Middle, La	est)		001	incaic	OI L	Catri	2. Date of	Reg. I Death	No.		3. Time of Death	_
	Physicia Medic			asiliou						Month Augu	st 1	7, 2012	^r 1	2:50 pM	ı
	Examir	er	4a. Facility Name (if not institution, given Holy Cross Hospit						Spring	eath	1	4c. County of De		7	
Track John	Funeral	Г	Social Security Number 6.			ast birthday)	If Under	1 Year	If Under 24		Birth	9. 8	Birthplac	e (State or Foreign	7
	Director		578-54-9280 Usual Residence of Decedent	1 🛂 M 2 🗆 F	86	Yrs.	Months	Days	Hours M	lin. (Month, May 1	Day, Year) (Country)		
	and show	٥	10a. State 10b. County		10c. City	y, Town or Loc	ation				,			Inside City Limits	_
	Maryl 28a-f otified	irec		gomery		Silver	Spri	ng						1 ☐ Yes 2 ☐ YN	0
	ith the 3a or it be n	ralD	10e. Street and Number 12801 Old Columbi	n Pilko An	+ /	20	10f. Zip (ode 0904				Citizen of What	Country	?	
	eath w	Funeral Director	11. Marital Status	12. Was Decedent E						(Specify Yes or N	US °-	A 14. Race - An	nerican l	Indian	_
36	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u>	<u>ج</u>	1 Never Married 2 Married	Armed Forces? 1 Yes 2 IX	No	l1	Yes, specif	y Cubar	n, Mexican, Pu	èrto Rican, etc.)		Black, Whi	ite etc	moun,	
Ö	atural	Completed	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.	_	16a. Deced					1		_		_
215	in 72 h e. nan "n Medi	J D D	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4 or 5	+)	(Give k	ind of work NOT use r	done di	uring most of v	vorking	16b.	Kind of Busines	ss/Indust	try	
2	d with lygien ther th	Be C	8			Auto	mobile	e Me	chanic			tomotiv	e Re	pair	
Maryland 21215-0036	be file ental H ked o ic eve	70 E	17. Father's Name (First, Middle, Last) Chris Papavasili	011						Name <i>(First, Midd</i> ne Konto		•			
ary	should n and Me 7 is mar raumati		19a. Informant's Name/Relationship (19b. Mailin	g Address (Rural Route Num			Zip Code	2090	<u>J</u>
Σ ش	1 and 2 s of Health item 27		Helen D. Papavasi	liou/Wife		1280	1 01d	Co1						pring, M)
Baltimore,	Page 1 anent of Hant of Hant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	C	lace of Disposemetery, crem	atory or oth	er place		Aug. 21,	.	Location - City	•		
	permit. Page 1: Department of I Important: If its any injury or of		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licer		bale	of He				2012		ver Spr	ing	, MD	_
ñ	Per la		James a	Coo O	2	50	Univ	vers	ity Bl		Silv	me Inc. er Spri	ng,	MD 20901	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each line	the dea	. Do not ente	the mode	of dying	, such as card	iac or respiratory	arrest,		Int	proximate erval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Failure T	o Th	rive							On	set and Death	
	Examiner			Sepsis	consequ	ence ory:									
	D #0	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	-	ence of):									_
	and and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pneumoni		ence off:							1		_
2	e be ey ysician e buriz	edical		d	,	,									
09/99	tificate ing phy e as th	Med	IF FEMALE:												_
POX	ath ce attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 Pregnant at	2 🔲 Fetal	death 3	Ectopic pre		,			23d. Date of o	leliv e ry Day	/ Year	
ם מ	the de by the	hysi	1 Yes 2 No 9 Unknown	9 Unknown	time or d	eatii 5	Other (spec							, roui	
ř.	ss that igned I be def	2	Part II. Other significant conditions	contributing to death bu	it not resu	ılting in the ur	derlying ca	use give	en in Part I.	23e. Dio	tobacco	use contribute	to the ca	ause of death?	
Records,	require been s should	Completed			_					17				y 4🛣 Unknown	
ecc	e has l age 2 s	ఠ								– 24a. Wa – aut per	s an opsy formed?	prior to	comple	findings available etion of cause of	
<u>.</u>	ian: Th	Be	25. Was case referred to medical					26. Pla	ce of Death (Ci		s 2 [3t]	No 1 □ Y	es 2] No	
Vital	hysic this ce al direc	욘	examiner? 1 ☐ Yes 2 ☒ No			R/Outpatient	3 🗆 DOA	Other	4 🗆 Nursing	Home 5 ☐ Re	sidence	6 ☐ Other (Spe	ecify)		Ī
0 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sempletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🗋 Accident Investigation	28a. Date of injury (Month, Day,		28b. Time of injury	28c	i. Injury work?	at ′es 2 ∐ No	28d. Describe	how inju	ıry occurred			
VISION	er dea rector: by the	ij	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Injur					es 2 11 NO			nd Number or R	ural Rou	ite Number,	-
2	oital or urs aft ral Dir			building, etc.						59.57	own, Stat				
	To the Hospital or within 24 hours afte To the Funeral Dir.	Medical	(Check 2 L. Medical Exam	sician: To the best of n iner; On the basis of ex- se Practitioner: To the	amination	and/or investig	nation, in my	/ opinion	death occurre	ad at the time date	and place	a and due to the	councilo) and manner state	d.
	Vithir To th		29b. Signature and title of certifier		best of in	y knowledge, t		icense		place, and due to		se(s) and manner ate signed (Mon			_
	7			plas					32332		Au	gust 17	, 20)12	
			30. Name and address of person who Suresh K. Gupta	completed cause of de a., MD 980	ath (Item :	23a) (Type, Pr orgia	_{int)} Avenu	e, S	ilver	Spring,	MD 2	0902			
	Stat	~	31. Date filed (Month, Day, Year) AUG 20 2012	62. Registrar	's Signatu	ire back	J.								_
	Registra		700 60 601	- sen	10.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

_			for State Registrar		State of iv	iai yiai		tificate			ivientai my	Reg. N	.2012	283	300
п	hysicia	n/	1. Decedent's Name (First, N		,				-		2. Date of De	eath		3. Time of I	
-	Medic	al	John Theodo								August		2012 ear	1:35	РМ
(المدارة	Examin	er	4a. Facility Name (if not instit					1	town, or Lo	ocation of Deat	th	- 1	c. County of Deat		
4.	Funeral		Manor Care F 5. Social Security Number			ge (In yrs. I	ast birthday)	If Under		If Under 24 Hrs		rth	9. Bir	thplace (State or	Foreign
	Director		012-16-6563 Usual Residence of Deceden		1 🕱 M 2 □ F	96	Yrs.	Months	Days	Hours Min	07/13/	ľýľ(Mas	sachuset	tts
	and show	ō	10a. State 10b. Co	unty			y, Town or Lo							10d. Inside City	/ Limits
	Maryl 28a-f otifie	Director	Maryland Mon	tgom	ery	No:	rth Be	thesd	a					1 🔀 Yes	2 🗌 No
	h the	a D	10e. Street and Number					10f. Zip				_	Citizen of What Co	-	
	th wit	Funeral	10500 Rockvi	11e					852				ited Sta		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Divo		12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates.	1933 No 1942		Was Decedent of Yes, special ☐ Yes 2			Specify Yes or No- to Rican, etc.)	•	14. Race - Ame Black, White Specify: Wh		
2-0	2 hou "natu edica	plet			Education rade completed)		16a. Deced	dent's Usua kind of work	l Occupati k done dur	on ing most of wo	rkina	16b.	Kind of Business	Industry	
121	thin 7 ene. than he M	Completed	Elementary/Seconday (0-	12)	College (1-4 or	5+)	life. D	O <i>NOT us</i> e rance	retired)			In	surance		
d 2	Hygik Hygik other ent, t	Be (17. Father's Name (First, Mid	dle, Last)			Ilisu	Lance			me (First, Middle				
lan	l be fi fental rked tic ev	임	Theodore Pap	pas							nce Mach		,		
ary	d 2 should be filed value and Mental Hyg alth and Mental Hyg 27 is marked other or traumatic event,		19a. Informant's Name/Relat				19b. Mailir	ng Address	(Street and	d Number or Ri	ural Route Numb	er, City o	or Town, State, Zip	Code) 2085	52
Σ.	nd 2 s ealth m 27 ner tra		Adrienne Pap	pas	/ Wife		1050	0 Roc	kvill	le Pike	Apt. 11	02 1	North Be	thesda,	MD
ore	ge 1 a it of H iffite or otl		20a. Method of Disposition 1 🔀 Burial 2 □ Crema	tion 3[☐ Remova! from State		lace of Dispo emetery, cren	sition (Nam natory or ot	ne of ther place)	8/	Date 16/2012	l	Location - City or		
ţ	it. Page rtment o rtant: If njury or		4 Donation 5 Oth			Gat	e of H			etery			lver Spr		
Ba	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Serv	ice Licer	lux								's Sons I		
1	<i>)</i>		23a. Part 1. Enter the diseas shock, or heart failure	e, or con ist only	nplications that cause one cause of each lin	d the deat e.	h. Do not ente	er the mode	of dying,	such as cardia	c or respiratory a	rrest,		Approximate Interval Betw	
-1	h sician/		Immediate Cause (Final disease or condition				Prost							Onset and De Years	eath 3
	Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ience of):								
		Jer	Sequentially list conditions, if any, leading to immediate	J	b. Due to (or as	a consequ	uence of):								
	D _ D	amir	Cause (Disease or iinjury	5	_		,								
	an and	EX	that initiated events resulting in death) Last		Due to (or as	a consequ	ience of):								
8760	ificate be executed g physician and as the burial repesi	dica		-	d										
387	rtifica ling ph e as th	/Me	IF FEMALE:	T	00- 4										
Box 6	leath certificate be executed eattending physician and d for use as the burial transit	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🗌 Feta	l death 3	Ectopic p				İ	23d. Date of del Month	ivery Day Ye	ar
Ď.	the dec	ysic	1 ☐ Yes 2 ☐ No 9 ☐ U <i>n</i> known		g ☐ Unknown	at time or c	ieall 5 L	1 Other (spe	ecity)					,	-
P.O.	that th	by Pł	Part II. Other significant cor	ditions	contributing to death b	out not res	ulting in the u	nderlyi ng c	ause given	in Part I.	23e. Did t	obacco	use contribute to	the cause of dea	ath?
S,	uires in sign	ed b	Atrial_Fibr	illa	tion						1 🗆	Yes 2	2 □ No 3 □ Pr	obably 4X U	<i>n</i> k <i>n</i> own
Sor	as bee 2 sho	Completed									24a. Was		24b. Were aut	opsy findings av completion of car	railable
Be	The la ate ha	Com									perfo	ormed?	death?	2 \square No	u36 01
ta	cian: ertific ector,	Be	25. Was case referred to med examiner?	ical	Hospital:					e of Death (Che	eck only one)				
Division of Vital Records,	Physi this o	P.	1 Yes 2 No		1 Inpati		ER/Outpatien				1		6 Other (Speci	fy)	
n 0	ding th. After funer	cate	1 🔀 Natural 5 🗆 Pe		(Month, Da		injury	M 28	Bc. Injury at work?	t es 2 □ No	28d. Describe l	how inju	iry occurred		
Sio	Atten	Certificate:	3 ∐ Suicide 6 ∐ Co	restigation ould not l termined	28e. Place of Inj					.5 2 110	28f. Location (Street a	nd Number or Rur	al Route Numbe	r,
\leq	al or safte		4 🗆 Florilloide — de	terminec	building, et	c. (Specify,)				City or Tox				
	Hospital or Attending Physician: The law requires that the death certifulation of the Anours attendant. To the Fundand Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a completed filled in by the funeral director.	Medical	29a. Certifier 1 X Certifier (Check 2 Medic	ying Phy	vsician: To the best of on the basis of e	my knowl	edge, death o	occured at t	he time, da	ate and place,	and due to the ca	use(s) a	and manner as sta	ted. ause(s) and man	ner stated
	the I	Me	only one) 3 Certification Cert	ying Nu	rse Practioner: To the	best of my	knowledge, c	leath occurr	ed at the til	me, date and pl	ace, and due to the	ie cause	(s) and manner as	stated.	
_				Tai	NIM	D							ate signed (Month		
			30. Name and address of per	son who	completed cause of a	leath (Item	23a) (Type: P		31319	9		Aug	ust 10,	<u> </u>	
			Loreto S. Al				, , , , , .		. Sui	ite 305	Bethesc	la,	MD 20814		
ı	Stat Registra		31. Date filed (Month, Day, Ye AUG 1		37. Registr	ar's Signat	ure de	Med.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Paskal Aphrodite Physician/ Matagust Day 5 2092 3:25P M Medical 4c. County of Death
Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 1 □ M 2 🔀 F 022-16-2706 May 15 1920 Albania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 🗌 Yes 2 🔀 No MD Frederick Frederick 10e. Street and Number ō 10g. Citizen of What Country? ms 23a or must be r Funeral 5957 Quinn Orchard Road N-114 21704 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 □ Divorced Specify White Year or Dates er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha other traumatic event, the N Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Petro Peters Angelina Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Williams - daughter 1091 Fairfield Station RD, Fairfield, PA 17320 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 XBurial 2 Cremation 3 Removal from State Oakwood Cemetery 8/10/2012 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of uneral Service Licensee 22. Name and Address of Facility Everly Wheatley Fuveral Home mo1453 1500 W. Braddock Rd Alexandria, VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) sue do membrancus Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 menths?

1 Yes No
9 Unknown 1 Live Birth
4 Pregnant a
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Diabetes hoors failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congostive certificate has autonsy performed 1 Yes Yes 2 funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 Yes 2 No Investigation Director Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 filled in by the 24 hours a Funeral I within 2 To the

12 State Registrar (Check

29b. Signatur and title of certifier

d (Month, Day, Year) Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Amend #20b Per FH JM 8/19 (Tipicate of Death 28302 Reg. No. 2. Date of Death Physician/ Medical Month _ 2012 DORIS **AGATHA** PICKETT 0520 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SHADY GROVE HOSPITAL ROCKVILLE MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 578-50-4635 Director 76 1 🗆 M 2 🗓 F APRIL 7, 1936 MD 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo MD PGCAPITOL HEIGHTS 28a-f Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 QUO AVE 20743 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secon ondary (0-12) College (1-4 or 5+) CHEF PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES A. FORD EVA HAWKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. Page 1 and 2 sh ment of Health a DETTA MITCHELL/DAUGHTER CHARRED WOOD CT., DISTRICT HEIGHTS, MD 20743 8 Date Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State NATIONAL HARMONY -12 LANDOVER, MD 4 Donation 5 Other (Specify) 21. Signat of Funeral Service License POPE FUNERAL HOMES, P.A. 22. Name and Address of Facility 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 0401085 Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be 1 Yes 2 No 3 Probably Junknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? 2 No Yes 2 1 Tes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) ျှ 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical Exam Certifying Nur 2 🗆 within 2. e Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 175F200CV 2ªW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research Bird, Suite 330, Pockrille, Marsland 20850 Hhmed Heshmat, MD 2401 State 3 Registrar

DHMH 17 Rev 06-2011

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		For State	State of Ma	aryland / Depa			Лental Нус	giene	10	20202
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Med Exam		4a. Facility Name (if not institution		Quade	4b. City, Town, or L	ocation of Death	August	4c. County		7:10 p ^M
		23349 Hurry	Road		C1eme	ents		St	. Mar	ry's
Funera	_	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birthp Count	lace (State or Foreign
Directo		220-80-6862 Usual Residence of Decedent	1 🗆 M 2 🛣 F	90 Yrs.			09/27/			ryland
and show at	ě	10a. State 10b. County		10c. City, Town or Loc	ation				10	0d. Inside City Limits
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the I	Ä	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
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21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho. the Medical Examiner must be notified at.	/Fu	11. Marital Status 1 □ Never Married 2 □ Mari	12. Was Decedent E Armed Forces?	l II	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
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Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To B	17. Father's Name (First, Middle, L		kerton		18. Mother's Nam		Maiden Surname • Gat		
iryli	ľ	William Fra 19a. Informant's Name/Relationsl			g Address (Street an	Esther				(ada)
Ma 2 shouth and 12 shouth and 12 shouth and 12 shouth and 12 is 27 is 12 is 12 is 12 is 13 is 14 is 15		Joseph L. Quad		1	Box 134,				tate, zip C	od <i>e)</i>
or Health of Health fitem 27		20a. Method of Disposition	<u> </u>	20b. Place of Dispos	sition (Name of		Date	20c. Location -	City or To	wn, State
Page 1		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Sacred	natory or other place) Beart	:	4/2012	Bushwo	od. I	MD.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service I	icense9	22	Name and Address	of Facility				
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6 ≥ 6 0		29b. Signature and title of certifier	MM	9	29c. License n			29d. Date signed		-2012
		30. Name and address of person	ha completed assessed	ooth (Item 22a) (Time D		557	21	000	00	040
) pme		Jennifer S		40900 Mercl		e. Leonar	rdtown.	MD 2065	0	
	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		,			-	
Regist	rar	AUG 2 1	2012 Lane	J. A.	we					

		-	For State Registrar	State of Marylan		artment of F tificate of L		ivientai my	giene Reg. No.	2012	28304
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
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سر	Examin J	er	18341 Rosecroft Re			Lexingto		n		• Mary	
	Funeral		5. Social Security Number 6. Sex		st birthday)		If Under 24 Hrs Hours Min.		rth	9. Birth	nplace (State or Foreign
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	and show	ior	10a. State 10b. County		, Town or Lo	cation		1//			10d. Inside City Limits
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	ems 2	Funeral Director	18341 Rosecroft Ro	2. Was Decedent Ever in U.S	3. 13.1	20653 Was Decedent of H	ispanic Origin? (S	pecify Yes or No		ed Stat	
စ္က	fter de , or it	þ	1 Never Married 2 Married	Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give		f Yes, specify Cuba 1 ☐ Yes 2 🏿 No		to Rican, etc.)		Black, White	
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Baltimore, Maryland 21215-0036	yelar tofHe Fiter or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 ☐ F	Removal from State	emetery, crer	osition (Name of matory or other plac		Date	Į.	ation - City or 1	
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	ospita hours uneral ily fillec	Medical	29a. Certifier 1 A Certifying Physic	ian: To the best of my knowl	edge, death	occurred at the tim	e, date and place	and due to the o	ause(s) and	manner as sta	ited.
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	₽ ₹ ₽ 8		29b. Signature and title of certifier	1 Sumo	lto	29c. Licens				signed (Month,	, Day, Year)
)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type. F	D3156	<u>. </u>		08/22	12012	
DR	me		Charles Benner, M	.D. 20945 Gr	eat Mi		. Great 1	Mills, M	D 20	653	
	Sta	te	31. Date filed (Month, Day, Year) AUG 2 2 20	32. Registrar's Signat		,					

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State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / De State of Maryland / De	Pertificate of Death		ene 201	2 28305
	Physicia Medic		1. Decedent's Name (First, Middle, Last) NORMAN PEDRO RICH		2. Date of Death Month	Day Year	3. Time of Death
many.	Examir		4a. Facility Name (if not institution, give street and number) PRINCE GEOLGE'S #OSPITAL	4b. City, Town, or Location		4c. County of Deat	:h
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 157 − 54 − 1908 1 ⊠ M 2 □ F 56 Yrs	ay) If Under 1 Year If Under		g. Birt Year) Co.	thplace (State or Foreign untry)
	yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County Md. Prince Georges Upper			7777	10d. Inside City Limits
	the Man or 28a-	Funeral Director	10e. Street and Number	Marlboro 10f. Zip Code	11	ng. Citizen of What Co	1 ☐ Yes 2 🕅 No ountry?
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9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	3 ☐ Widowed 4 ☐ Divorced I ☐ Yes 2 IX No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Ori- If Yes, specify Cuban, Mexicar □ Yes 2 X No Specify: 		Black, White	
Maryland 21215-0036	hin 72 ho ne. than "nai ie Medici	Completed	(Specify only highest grade completed) (Gill Elementary/Seconday (0-12) College (1-4 or 5+)	ecedent's Usual Occupation ive kind of work done during most a. DO NOT use retired)	st of working	6b. Kind of Business	·
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Baltimore,	it. Page rtment or rtant: If in njury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	rematory or other place) le Park Crem.	8/16/2012	Riverdale	Park, Md.
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	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition TATAL CALLS disease or condition	enter the mode of dying, such as		t,	Approximate Interval Between Onset and Death
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	o o wit		29b. Signature and title of certifier GADES MD	Am 29c. License number D007 L	1447 290	d. Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type G. ADESAM, MD 3001 HOSPIT		EVEKLY MI	> 20785	
	State Registra	~	31. Date filed (Month, Day, Year) AUG 16 2012 32 Registrar's Signature	aled	,		

12-06105 Wolford Redfearn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

olfora Re			1- For State Registrar		ate of Maryl	-	rtificate of				Reg. No.	201	2 2830
Phy edical Ex	sicia cami		1. Decedent's Name	Wolford		rn				2. Date of De Month August 1		Year	3. Time of Death 0128 hrs
			4a. Facility Name (if 14014 Mars)		n, give street and n	umber)	4	b. City, Town, or Hagerstowr		eath		nty of Death nington	
Fun Dire			5. Social Security No. 577 82 034		6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min.	3irth (MM/DD/Y	YYY) 9. Bir Foreig Co	thplace (State or In untry New Jersey
	w any		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Locatio						10d. Inside City Limits
aryland	23a or 28a-f show any notified at once,	Director	Maryland 10e. Street and Num		ery		Burtons	ville 10f. Zip Code			10g. Citizen o	f What Cour	1 Yes 2 XNo
th the M	23a or 2 notified	I Dire		.4602 A1	manac Driv			208				l State:	
fter death wi	l", or items	y Funeral	11. Marital Status 1 XX Never Marrie 3 Widowed			2 X No	If Ye		, Mexican, Pu	(Specify Yes or N erto Rican, etc.)		Vhite, etc.	can Indian, Black, BCk
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	than "natura edical Examir	Completed by	15. Decedent's Education Elementary/Second 12		cify only highest gra			s Usual Occupat st of working life			16b. Kind o	f Business/I	ndustry
1215-0036 I be filed within 7 ental Hygiene.	arked other vent, the M	Be		nur McC	ueen				Shir	ame (First, Middle ley Redfea	arn		
MD 21 12 should the th and Mer	27 is m ımatic e	2	19a. Informant's Nam Debra Mo							or Rural Route No Burtonsvill			, Zip Code)
Baltimore, Permit. Pages 1 and Department of Healt	nt: If item		20a. Method of Disport	Cremation		om State	Place of Disposit crematory or othe SUFFECTION	er place)		Date Aug 17, 201			Town, State
Baltin permit P Departme	Importar injury or		21. Signature of Fun			MOISSS	22. Na	ame and Address	of Facility L	-			Old Alexandri
Physic /Med Exami	cal		23a Port I. Enter the failure. List only Immediate Cause (F	one cause inal disease	on each line. a. Complicati	aused the death	n. Do not enter the	e mode of dying,	such as cardi	ac or respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and Death
			or condition resulting	ditions,	b	a consequence o							
ited	ansit	Examine	if any, leading to imr cause. Enter Under (Disease or injury the events resulting in d	lying Cause at initiated	С	a consequence of							
), be execu	hysician and e burial - transit	Medical	UNPENDED		AMENDED								
ox 687	for use as the		IF FEMALE: 23b. Was decedent p past 12 months?	,	e 1 Live b	ant at time of de	2 Feta	il death 3 [er (Specify)	Ectopic pre	egnancy	23d. Date Monti	e of delivery h D	ay Year
P.O. E	signed by the	Ď	Part II. Other signifi	cant conditi	ons contributing to	death but not r	esulting in the un	derlying cause g	iven in Part I.				he cause of death?
of Vital Records, ng Physician: The law requir	nas been 2 should	Completed								perf	s an 24 opsy ormed? 2 ✓ No		opsy findings available ompletion of cause of s 2 No
Vital Physician:	tals certificate I director, page	o Be (25. Was case referre examiner? 1 ✓ Yes 2		Hospital: 1	Inpatient 2	ER/Outpatient		of Death (Che	eck only one) ursing Home 5	Residence	6 🗸 Other:	Scene
	the funera	ation:	27 Manner of Death 1 Natural 2 Accident	5 Pend	28a. Date (Month Unknow tigation	of Injury , Day,Year) /N	28b. Time of Inj UNKNOWN		y at Work? ′es 2 ✔ No		how injury occ nped from l		
Division Hospital or Attendi	completely filled in by	Certification:	3 Suicide 4 Homicide	6 Could deter	not be mined (Specify)	Bridge	ome, farm, street			or Town, 14th Street E	State) Bridge, Wash	ington, DC	
To the Ho within 24	completely	Medical	(Check only		ysician: To the bes niner:On the basis and manner s	of examination a							
H 8 H	5	Me	29b Signature and ti	itle of certifie		· .		29c. License O.C.N			29d. Date s August 1		th, Day, Year)
00	`\		30. Name and address Patricia Aron	ica-Pollak	MD. Assista		•	00 W. Baltim	nore Street	t, Baltimore, M	1D 21223		
	St	ate	31. Date filed (Month	, Ad Year)	0 2010 ^{32. Re}	egistrar's Signatu	ure /	r. Kal					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

12-06043 Tracy A. Reuschel		pe or Print in E tate of Maryland	l / Departm		alth an		Hygiene) 2 2830
Physician/ Medical Examine	1. Decedent's Name (First, Midd	lle,Last) REUSCHEL					2. Date of De	eath Day Yea	3. Time of Death
medical Examine	4a. Facility Name (if not institution	on, give street and number	er)			Location of Dea	August 1	4c. County o	of Death
Funeral	Southbound 270 at B 5. Social Security Number		age (In yrs. last birt		derick Inder 1 Yea	r If Under 24H	rs. 8. Date of E	Frederic	9. Birthplace (State or
Director	218-56-9186	1 M 2 X F	60		nths Day			31, 1951	Foreign Country) Marylar
any	Usual Residence of Decedent 10a. State 10b. County		10c, City, Town	or Location					10d. Inside City Limits
k	Maryland Mont	gomery		rsburg					1 Yes 2 X No
the Maryland so or 28a-f sh stified at once		Drive	1	10f.	Zip Code 20)877		10g. Citizen of Wh United St	
r death with or items 23 r must be no Funeral	11. Marital Status 1 Never Married 2 X N	1 Yes				spanic Origin? (n, Mexican, Puer		lo- 14. Race White	- American Indian, Black, , etc.
urs after tural", aminer	3 VVidowed 4 Di	vorced If Yes, Give Year or Dates: ecify only highest grade co	ompleted) 16a.		2 X No	specify: ion (Give kind o	f work done	Specify: 16b. Kind of Bus	White siness/Industry
2 2 1 2 1 5 - 0036 hould be filed within 72 hours after death with the Maryland hould be filed within 72 hours after death with the Maryland is marked other than "natural", or items 23a or 23a-f show tite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 o	r 5+)			. DO NOT use re		Montgon	mery County
215-C be filed v mal Hygi rked oth ent, the I Be Co							ne (First, Middle Hallier	, Maiden Surname)	
MD 21215-0036 to 2 should be filed within 7 thin and Mental Hygiene. In 27 is marked other than anmatic event, the Medical To Be Comple								umber, City or Town	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23a-f shoo injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 X Cremation	n 3 X Removal from S	20b. Place o	of Disposition (Normal of Disposition (Normal	Name of cer	netery, Au	gust 17	20c. Location -	City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If Itee	4 Donation 5 Other S 21. Signature of Funeral Service			22. Name a	nd Address	of Facility De		eral Home ithersbur	e rg, MD 20877
Physician	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	complications that cause on each line.	d the death. Do no						
Examiner	or condition resulting in death)	Due to (or as a con							
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated	bbue to (or as a con							
nd of the ransit		Due to (or as a con:d	sequence or):						
be exection and unital - t	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	ome of pregnancy 2 at time of death 5		_	Ectopic pregr	nancy	23d. Date of d Month	delivery Day Year
the deat by the at ched for	1 Yes 2 No 9 V Uni	5 Onkiowii	th but not resulting	in the underly	ing cause g	iven in Part I	23e Did	tobacco use contrib	oute to the cause of death?
P.C res that signed to be deta				, (110 = 110 011)	ing cause g	Avoir in Fact.			Probably 4 V Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ragter death. To after death. Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach errification: To Be Completed by P								ppsy pr ormed? de	fere autopsy findings available for to completion of cause of eath?
ital Reichen: The certifical rector, pa	25. Was case referred to medica				26.Place	of Death (Check	1 Yes	2 No 1	Yes 2 No
f Vit Physical er this carthing and direction	examiner? 1 ✓ Yes 2 No 27. Manner of Death			itpatient 3		Other Nurs		Residence 6 V	
ion of tending Pt eath. ior: After the funeral	1 Natural 5 Pend	28a. Date of Inj (Month, Day Aug 12, 201)	Year) 1510			es 2 ✓ No		ver of motor ve	ehicle involved in motor
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page ledical Certification: To Be Com	3 Suicide 6 Coul	d not be 28e. Place of I	njury - At home, fa terstate/Expre		ory, office bu	uilding, etc.	28f. Location or Town,	(Street and Number State)	r or Rural Route Number, City Creek, Frederick, MD
To the Hosp within 24 ho To the Fune completely f		hysician: To the best of r	amination and/or in						
N S T S T S	29b. Signature and title of certifie	and manner stated er	<u>. </u>	2	9c, License	number	·	29d. Date signed	d (Month, Day, Year)

10

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD.

State Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Montg Day, Year) 2012 37. Registrar's Signature

OCME

August 13, 2012

O.C.M.E.

12-06051

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Saharath Rochana		chit I- For State	Sta	ate of Maryl				d Mental H	ygiene	21	012 2830
Dharisia		Registrar 1. Decedent's Name	First Middle	a Last)	Ce	rtificate o	Death		2. Date of Dea	teg. No.	3. Time of Death
Physician Medical Examine	"	Saharath			aka	Sam Roc	hanavich:	it	Month August 12	Day Year	
		4a. Facility Name (i		n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County o	
		Suburban H		0.0	17 Ame (In	loot hinth do	Bethesda It Under 1 Voc	s Hillader 24Hrs	In Date of B	Montgon	
Funeral Director		5. Social Security N 226-35-77		6. Sex	7. Age (In yrs. 41		If Under 1 Year Months Days		_		9. Birthplace (State or Foreign
Director	-	Usual Residence of		1 M 2 F	71	Yrs			July 8	3, 1971	Country) CT
any	_		10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits
Maryland 28a-f show d at once.	۱,	MD	Mo	ontgomery		Rockvil.	le				1 Yes 2XX No
Marylz 28a-f d at o	Director	10e. Street and Nur	mber		-		10f. Zip Code			10g. Citizen of Wh	at Country?
h the 33 or totifie			Orienta	al Street			208			USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	=	11. Marital Status 1 XNever Marrie	ed 2 Ma	12. Was De			is Decedent of His es, specify Cuban			0- 14. Race White	- American Indian, Black, e, etc.
ter dez	-1	3 Widowed		1 Yes	2 X No	1	Yes 2 X No	specify:		Specify:	Asian
ours af	<u>8</u>	15. Decedent's Ed		or Dates: cify only highest gra			it's Usual Occupat			16b. Kind of Bus	
6 72 hc		Elementary/Seco	ndary (0-12)	College (1-4 or 5+)		ost of working life.		rea)	Dool E	
003 withir giene.	отріете	17. Father's Name (Cient Middle			rrope.	rty Manag		/First Middle	Real E	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	200	Anant Ro								nkrachan	
212 buld be Ment mark	0	19a. Informant's Na				19b. Mailing	Address (Stree				n, State, Zip Code)
MD d 2 shoulth and a 27 is numati	L			chit/Brot						ille, MD	
ore, so I an of Hea	1	20a. Method of Disp 1 Burial 2		3 Removal f		Place of Dispos crematory or ot	ition (Name of cer ner place)		Date	1	City or Town, State
Baltimore, pernit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Sp	ecify:	Met		an Crema	tory	ug. 15, 2012	Alexand	lria, VA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service	Licensee	20	Fr	ancis J.	Collins	Funera	l Home In	nc. ring, MD 20901
Physician	+	23a. Part I. Enter th			caused the death	n. Do not enter t	he mode of dying,	such as cardiac o	r respiratory ar	rest, shock, or hea	art Approximate interval
/Medical	1	failure. List onl	•	on each line. _{a.} Multiple In	juries						Between Onset and Death
Examiner	1	or condition resulting			a consequence of	of):					
	<u>.</u>	Sequentially list cor		b Due to (or as	a consequence of	of):					
list C		cause. Enter Unde	rlying Cause lat initiated	c.		-6)					
n and a secuted	נ	events resulting in	death) Last	d.	a consequence o	or).					
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Box 68760 c death certificate the attending phys ed for use as the b		past 12 months		I I LIVE	birth nant at time of d	ooth -	tal death 3 [her (Specify)	Ectopic pregna	ncy	Month	Day Year
Box 6 e death cer the attendi	Pnysici	1 Yes 2 N	lo 9 📗 Unk	nown 9 Unkr	nown					1	
C the State of	2	Part II. Other signif	icant conditi	ons contributing	to death but not i	resulting in the u	inderlying cause g	given in Part I.			bute to the cause of death? Probably 4 Unknown
S, Fluires I quires I quires I qui pe an sign IId be a lide be a l									24a. Was		Vere autopsy findings available
cords, law requir has been s	Сошріете								auto	psy pi	nor to completion of cause of leath?
Vital Recysician: The his certificate director, page	5							(5 4 (0)	-	2 No 1	Yes 2 No
ital sician: s certi irector	ן מ	25. Was case referr examiner?		Hospital:	Inpatient 2	FR/Outpatient		of Death (Check of Other Nursin	, ,	Residence 6	Other:
Division of Vital Records, tal or Attending Physician: The law requir is a star clean. In Director: After this certificate has been sited in by the funeral director, page 2 should be seen in the funeral director.		1 ✓ Yes 27. Manner of Deat	No No	28a. Date	of Injury	28b. Time of I		ry at Work?	28d. Describe	how injury occurre	ed
ion of tending Pheath.	Certification:	1 Natural 2 ✓ Accident	5 Pend	ing Aug 12	h, Day Year) , 2012	2042 hrs	1 🗆 Y	res 2 🗸 No	Operator of	motorcycle in	nvolved in collision
Divisi pital or Att ours after de teral Direct filled in by	<u> </u>	3 Suicide	6 Could	not be 28e. Pla	ce of Injury - At h	nome, farm, stre	et, factory, office b	uilding, etc.	28f. Location (or Town, S		er or Rural Route Number, City
spital Di	5	4 Homicide			Major Roa				High Gables	Drive & Great S	Seneca Highway, Bethesda,
Divisior To the Hospital or Attend within 24 bours after death To the Funeral Director: completely filled in by the	ᅙ	(Check only		nysician: To the be niner:On the basis							
Tot with Tot com	Medical	29b. Signature and		and manner			29c. Licens				ed (Month, Day, Year)
10		0-7)				O.C.I	M.E.		August 13,	2012
	-	30. Name and addre	ess of person	who completed cau	use of death (Iter	m 23a)					
		Donna M. V			Medical Exa		W. Baltimore	Street, Baltin	nore, MD 21	1223	
Stat Registra	-	31. Date filed (Mont	1 5 20	12 Jenes	egistrar's Signat	ture grands					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28309 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08/03/2012 WILLIAM HENRY REID 1748 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 🕅 M 2 🗆 F 01/05/194 Director 240-68-1497 71 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD PRINCE GEORGE'S UPPER MARLBORO 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 16205 VILLAGE DRIVE WEST 20772 UNITED STATES ral", or items? Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 Black, White, etc Completed by 1 Never Married 2 X Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 🗆 Widowed 4 🗆 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than ' life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE ENGINEERING MANAGER permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Eirst, Middle, Maiden Surname) ဂ WALTER REID RUBY ELIZABETH BARFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDIE REID/ WIFE 16205 VILLAGE DRIVE WEST, UPPER MARLBORO, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MARŸLAND POTETERANS CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/13/2012 CHELTENHAM, MD 21. Signature Funeral Service Lice 22. Name and Address of Facility POPE FUNERAL HOME, PA arr Immons moors 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_ician disease or condition resulting in death) Medical Due to (or a la onsequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director, Hospital Other Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29a, Certifier 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on ith, Day, Year) 29b. Signatu d title of cer 29c. License numbe D16 22M completed cause of death (Item 23a)

Registrar

DHMH 17 Rev 7/2009

State

OF

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2001

		For		St	ate of	Maryla	and / De	epar	tment	of H	ealth a	and M	ental H	ygien	e 21	112	2	8310
		State Registrar	- (Fire to Adiodal)					Certi	ificate	of D	eath			Reg. N	lo.) {_	_	
Physicia Medic		1. Decedent's Name WILLIAM		o, Last) OBINS(ON								2. Date of D		ay 20	O Year	3. Time	of Death P M
Examin		4a. Facility Name (if		_							ocation o			4	c. County	of Death	•	
		FT. WASHI 5. Social Security No		NURSI1			CENT]		FT.		INGTO		O Data of D		PG	0. 5:41	1 01	
Funeral Director		239-60-44	154	1 X M 2		77	Yrs	// N	Months	Days	Hours	Min.	8. Date of B	935°		9. Birth Coul		e or Foreign NC
show	5	Usual Residence of 10a. State	10b. County			10c. 0	City, Town o	r Locat	tion								10d. Inside	City Limits
Maryla 28a-f	Director	MD	PG			OX	ON HI	LL									1 🛚	Yes 2 ☐ No
h the la or 2	al Di	10e. Street and Nur	mber						10f. Zip	Code				10g. C	Citizen of \	What Cou	ntry?	
ith wit	Funeral	7503 ABB	BINGTON			ent Ever in U	10 .	10 10/0		745	nania Oria	in 2 (C = 2 =	if Nos or No	U:				
pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried 1	med Force The Yes 2 Yes, Give ear or Date	es? ! XNo	J.S.	If Y	es, specil	y Cuban	, Mexican	, Puerto F	ify Yes or No lican, etc.))-	Blac	e - Americk, White,		
2 hou "natu edical	Completed	(Spe	15. Deceder	nt's Educationst grade con			I (G	ive kin		done du	tion iring most	of workin	g	16b.	Kind of B	usiness In	dustry	
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iled w Il Hygi othel rent, t	Be	17. Father's Name (First, Middle, I	.ast)				<u> 1 1 1 1 </u>	111 '			r's Name	(First, Middle	e, Maider	n Surname	=)		
d be f Menta arked atic ev	P	JOHN HEN	RY ROB	INSON							EFFI	E DA	LE					
id 2 shoul saith and I n 27 is m er trauma		19a. Informant's Na CHRISTIN				FE		_					Route Numb					
Page 1 an nent of He int: If iten ry or oth		20a. Method of Disp 1 🌠 Burial 2 4 🗀 Donation	☐ Cremation	3 🗌 Remo	val from Si	tate	. Place of Di cemetery, o	cremat	tory or oth	er place,	' ! ·	–11 ^D	12	1	Location -	-	own, State	
permit. P Departm Importa any inju		21. Signature of Fur		icensee	, M	509		22. N	Name and	Address	of Facility	POP	E FUNE FORES	RAL	HOME	S, P	.A.	
	П	23a. Part 1. Enter t shock, or hear		- 6 5	ns that cau	us od the de	ath. Do not	enter t	the medie	of dying,	such as o	ardia dr			,,		Approxin	
ysician/ Medical		Immediate Cause (disease or conditio resulting in death)	(Final	a	no	ld	her	0	(le	w	ev	R	0				Interval E Onset ar	
Examiner	ŀ	Sequentially list co	nditions,	b. —	,	as a conse												
uted d ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or that initiated events	nmediate rlying iinjury		Due to (or	as a conse	equence of):											
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ificate ig phys as the	Medi	IF FEMALE:		T														
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2 G 9 Unknown	months?	1 4	Live Bir	me of pregi th 2 Fe nt at time o	etal death		Ectopic pr Other (spe							te of deliv	ery Day	Year
ires that the signed by a deta		Part II. Other signif	icant condition	ons contribut	ing to dea	th but not r	esulting in th	he und	lerlying ca	use give	n in Part I.		23e. Did	tobacco	use contr	ribute to t	he cause o	f death?
v requires s been sig should b	ted												1 🗆	Yes 2	2 No	3 🗌 Pro	bably 4[Unknown
sician: The law re certificate has be irector, page 2 shu	Completed by												24a. Was auto per 1 \(\sum \) Yes	opsy formed?	, ,	Were auto prior to co death? 1 Yes	mpletion o	s available f cause of
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ending l ath. r: After ne funer	Certificate:	1 Natural 2 Accident	5 Pendin	g gation	a. Date of (Month,	Day, Year)	lnjur		M 28	c. Injury a work? 1 🔲 Yo	es 2 🗌		Bd. Describe	how inju	ry occurre	ed		
ial or Atters as after de al Directo		3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could determ			Injury - At l , etc. (Spec	home, farm, <i>ify)</i>	, street	t, factory,	office		2	8f. Location City or To			er or Rura	Route Nu	mber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	(Check 2	Certifying Medieal E	xaminer: On	the basis	of examinati	ion and/or in	vestiga	ation, in m	y opinion,	, death oc	curred at t	he time, date	and plac	e, and due	e to the ca	use(s) and I	manner stated.
		29b. Signature and t	title of certiller	>		\sim			29c.	icense r	number - 2 4	5-3	5	29d. Da	ate signed	(Month,	Day, Year)	012
5m		30. Name and addre								01,	CLIN'	ron,	لــــــا D 207:	<u> </u>	V			,
Stat		31. Date filed (Month	h, Day, Year)		-	istrar's Sign	oturo .	ark										
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 2831 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Sullivan Henry 4:25 a^M 2012 Medical August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard Gilchrist Hospice Columbia 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year, 9/27/1926 Days Hours 033-14-2271 Director 1 M 2 □ F MA 85 Yrs Usual Residence of Decedent 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Funeral Director 1 Ves 2 X No Accomack Greenbackville Va 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3444 Captain's Corridor 23356 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc 1 √ Yes 2 □ No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Lepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event than "na once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Tire Industry Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Vaughn Sullivan Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6165 Wooded Run Drive, Columbia, Md. 21044 Ann Losak/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Feremation 3 Removal from State Cremation Center of Md. 8/20/2012 4 Donation 5 Other (Specify) Hanover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. more 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ weaps disease or condition resulting in death) ntov-Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) **Hos**pital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant : 9 ☐ Unknown 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ibrillation CArdiomyo Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 prior to completic 2 No 1 Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{array}{c} \text{Other (Specify,} \) Hospice 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 IDOA the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation after deat n 24 hours after der Je Funeral Director Sietely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 02522 curo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month)

14

6701

egistrar's Signature

N. Charles St. Balto, and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bin

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are 2 egible 283 | 2
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		,,	Cer	tificate of	Death			Reg. N	0.		
	Physicia	nn/	1. Decedent's Name (First, Middle, Las	st)						2. Date of De	ath		3. Time of	Death
	Physicia Medi		Robert Schipper							August	13	2012 ear	10:4	0 A™
	Examir	ner	4a. Facility Name (if not institution, given Homecrest Assiste				4b. City, Town,		n of Death p ring			c. County of Dea		
***	Funeral		5. Social Security Number 6. S		(In yrs. last bi	irthday)	If Under 1 Yea		er 24 Hrs.	8. Date of Bir			irthplace (State o	r Foreign
	Director			⊠ M 2 □ F 7 9		Yrs.	Months Day	s Hours	1 1	(Month, Da Dec. 17	y, Year)	C	ichigan	rroreign
	/land f shov	į	10a. State 10b. County	1	10c. City, Tov	wn or Loc	ation						10d. Inside Ci	ty Limits
	Mary 28a-i	Director	Maryland Montgor	nery	Silv	ver S	Spring						1 🗆 Yes	2 🛚 No
	s 23a or	Funeral D	10e. Street and Number 14510 Homecrest F	Road			10f. Zip Code 209				_	itizen of What C		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 XX Yes 2 No If Yes, Give KO Year or Dates.			Vas Decedent of Yes, specify Cu ☐ Yes 2 🛣 N			cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify: Whi	te, etc.	
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121	ithin 7 ene. • than	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)) F		NOT use retire preneur	′				Distri	Manufact bution	uring
and 2	be filed w ental Hygi ked other c event, t	0.1	17. Father's Name (First, Middle, Last) Edward Shipper			311616	premeur	18. Mot	ther's Name	(First, Middle, Ltsky				
Baltimore, Maryland 21215-0036	2 should Ith and Me 27 is mar		19a. Informant's Name/Relationship (7. Joyce Shapiro / Da									or Town, State, Z MD 21701		
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Baltin	permit. P Departm Importar any injur		21. Signature eral Serv Licens			Ŕe	·Sehaved	res F ulfac	Yal S	Servcie	s, S	Skkot Co		
~14	Ph _y sician.		23a. Part 1: Enter the disease of com shock, or hear failure. It st only of Immediate Cause (Final disease or con lition	plications that caused the cause on each line. Acute Car		not ente	r the mode of dy					rederic	Approximate Interval Betwoonset and D	e ween
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8760			IF FEMALE:											
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Division of Vital	al or Atter s after des I Director d in by th	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			arm, stre	et, factory, office			28f. Location (S City or Tow			ural Route Numb	er;
_	ne Hospita n 24 hours ne Funera sletely fille	Medical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exar se Practitioner: To the b	mination and/	or investi-	gation, in my opi	nion, death	occurred at	the time, date a	nd plac	e, and due to the	cause(s) and mar	nner stated.
	To the within To the Comp	-	29b. Signature and title of certifier	Mh. 1	hin	1)	29c. Licer	25733			29d. Da	ust 15,	th, Day, Year)	
	51		30. Name and address of person who of H. Brandis Marsh,											
	Stat Registra		31. Date filed (Month, Day, Year) AUG 16 20	32. Pegistrar's	Signature		ake							

	Ame	nde	ed# 7, 08/23/2012 Plea									_	ible.		
			For State Registrar	State of M	aryıan		artment of tificate of		and iv	ientai Hy	/gien Reg. N	20	012	28	313
	Physicia Media		Decedent's Name (First, Middle, Earl Ambrose S	,						2. Date of De Month 08		ay 5 2	2012	3. Time of 1:48	Death P M
a salanda da Examir		4a. Facility Name (if not institution, Hospice of St.	Mary's			4b. City, Town,	away				c. County	lary'			
	Funeral Director		5. Social Security Number 233-66-8337 Usual Residence of Decedent	6. Sex 1 🕅 M 2 🗆 F	je (In yrs. Ia 71	ast birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	0601960 -08/15	/1/94 /201	1 2	Count	lace (State or ry) Virgin	_
	Maryland 28a-f show otified at	Director	10a. State 10b. County	Mary's		y, Town or Lo							10	0d. Inside Cit	-
	with the 23a or ust be n	Funeral D	10e. Street and Number 29821 Oak Road				10f. Zip Code 20659					itizen of W	hat Count	ry?	
396	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Š	11. Marital Status 1 □ Never Married 2 ▼ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of f Yes, specify Cub	oan, Mexican	i, Puerto F	cify Yes or No Rican, etc.)		14. Race Black	- America k, White, e	tc.	
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Baltimore,	Page 1 an ment of He ant: If iter ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 4 ☐ Donation 5 ☐ Other (S)	3 🗌 Removal from State	Brf	lace of Dispo	sition (Name of natory or other pla d—ECNOIS	rce)	D	ate	20c. l	ocation -	-	wn, State	
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Divis	vital or Att urs after d ral Direct		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determir	building, etc	(Specify)					8f. Location (City or Tov	vn, State	2)			5
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3)pme		30. Name and address of person was Jennifer Schmid	lt 40900 Mer	chant	t Lane	,	205 Le	eonar	dtown,	MD	2065	0		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security Number			last birthday)	If Under 1 Ye		24 Hrs.	8. Date of Bir		9	Birthpla	ngton ace (State or Fo	oreign
Director		219-54-5941 Usual Residence of Decedent	1 ■ M 2 □ F	60	Yrs.	Months Day	/S Hours	Min.	Feb. 11	, Year) 195	52	Country Mar	yland	
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permi Depar Impoi any ir		> ///MII/()-YA	MINA MOI	 393-	22	Name and Add Mo. 26401 R	leswort idge Ro	th-W	illiams Damasc	, P.	A., F	uner	al Home	5
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fficate ig physas the	Medi	TE SERVICE	d											
ath certifica attending p	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregna	ancy al death 3	Ectopic pregna	incy				23d. Date of			
t the deal by the at tached fo	Physician/Medical	1 Yes 2 No	4 ∐ Pregnant at 9 ☐ Unknown	time of	death 5	Other (specify)				İ	Month	D	ay Year	
that th		Part II. Other significant condition	ns contributing to death bu	ut not res	sulting in the ur	nderlying cause	given in Part I	i.	23e. Did to	obacco u	use contribut	te to the	cause of death	1?
requires the special should be a	Completed by								1 🗆	Yes 2	□ No 3 [☐ Proba	bly 4 Onkr	nown
has be	nple								24a. Was autor	osy	prior	r to comp	y findings available	able e of
n; The Is ficate ha n, page		25. Was case referred to medical							1 🗌 Yes	rmed? 2 2 No	deat	rh? Yes 2	□ No	
ysician; is certific director,	To Be	examiner? 1 \(\sum \) Yes \(_2 \) \(\sum \) No	Hospital:	ent 2 🗆	ER/Outpatient		Place of Deat		only one) me 5 🗷 Resid	donoo 6	Other /S	`noniful		
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al or Attenos after deat Director: d in by the		4 Homicide determin	ned 28e. Place of Injur building, etc.			et, ractory, omic	3	- 1	28f. Location (S City or Tow			Rural Ro	oute Number,	
To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying I	Physician: To the best of r caminer: On the basis of ex	ny know	ledge, death or	ocured at the tin	ne, date and p	olace, an	d due to the car	use(s) an	d manner as	stated.	o(s) and manner	otatad
the Fithin 24	Σ .	only one) 3 Certifying I 29b. Signature and title of certifier	Nurse Practioner: To the b	pest of m	y knowledge, de	eath occurred at	the time, date	and plac	e, and due to the	e cause(s	and manne	r as state	ed.	Stateu.
F > F &		De Ala	200//116					. 5	8	A 17a	te signed (Me		y, rear) 2012	Z
V		30. Name and address of person w	ho completed cause of de	/	1	int) //	682 ersto	***	MAC	10-7	n A	W 25		
Stat	e	HVU Daker 7 31. Date filed (Month, Day, Year)	VOSTURE 32. Registrar		ture #	Hag	e15101	Wh	MD		×1-18	大		
Registra		AUG 1	12012 Janes	مهد	13. 19	action								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10d. Inside City Limits

Interval Between Onset and Death

Day

Year

1 X Yes 2 No

Registrar DHMH 17 Rev 06-2011

State

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 p^{M} Jean K. Stevenson 3:00 August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Director 216-40-6110 1 🗆 M 2 🍱 F 94 Dec. 14, 1917 PA Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 XXo 10e. Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be n 10g. Citizen of What Country? Funeral 9610 Sutherland Road 20901 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fishers ည Thomas Milton Kunes Marian Louise Riddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Mimi Stevenson/Daughter 9610 Sutherland Road, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Alexandria, VA 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W ., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Myocardial Infarction Medical Due to (or as a consequence of) Examiner Acute Coronary Artery Syndrome Sequentially list conditions Examine in any, reading to immediate cause. Enter Underlying Due to (or as a consequence of) an and that the death certificate be executed Cause (Disease or injury Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burile Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 XNo Day Month Year Pregnant at time of death the 9 Unknown P.O. been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? this certificate Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔼 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗷 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Hospital or Attending Physician: of Vital Division 124 hours after death. E Funeral Director: Aft letely filled in by the fur within 2 To the I ည 12

> G. Patrick Murphy, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year, 32. Registrar's Signature AUG 20 2012

Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

30. Name and address of person who cert

pleted cause of death (Item 23a) (Type, Print)

🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contriving Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D41624

City or Town, State

29d. Date signed (Month, Day, Year,

August 18, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY G931 Department of Health and Montal Hygione

			1 - For State RegistrarAMEND#19a	perINE				artment of <i>tificate of</i>			nentai Hy	giene Reg. N	.201	2	28317	
П	Physicia	in/	1. Decedent's Name (First, Mid	dle, Last)		Scia	arretta	<u> </u>			2. Date of De	eath		Т	3. Time of Death	
-	Medic	cal	HUGO 4a. Facility Name (if not instituti				ETA FE	RRERESO			AUG.		$\frac{201}{1}$		7:53 P ^M	
	Examin	ier	SUBURBAN H	, 0		')		4b. City, Town,	or Locatio			40	c. County of De MONTGOI		37	
	Funeral		5. Social Security Number	6. Sex		Age (In yrs. Ia	ast birthday)	If Under 1 Yea	r If Und	er 24 Hrs.	8. Date of Bir		9. B	irthplac	ce (State or Foreign	
	Director		NONE	_	X M 2□F	70	Yrs.	Months Day	s Hours	Min.	(Month, Da		C	Country)		
	nd how at	٦	Usual Residence of Decedent 10a, State 10b, Coun			70	, Town or Loc	cation			JULY 3	, 15	942 A		NTINA Inside City Limits	
	anyla la-f s ified	Director	MD. PRIN	CE CI	EORGES		,,		TE					100	1 X Yes 2 No	
	or 28	ä	10e. Street and Number	CE GI	EURGES			RIVERDA 10f. Zip Code				10g. C	itizen of What C	Country		
	s 23a	Funeral	5615 KENN	EDY S	ST.			20	737				ARG	ENT	INA	
	death item ner n		11. Marital Status		12. Was Deceder Armed Forces	s?		Vas Decedent of Yes, specify Cu	Hispanic C ban, Mexic	Origin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Am			
36	within 72 hours after death with the Maryland piene. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 M 3 ☐ Widowed 4 ☐ Divorc		1 Yes 2 If Yes, Give Year or Dates		1	XYes 2□N		fv:			Black, Wh			
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Maryland	ild be filed v Mental Hyg narked othe	10 E	17. Father's Name (First, Middle LUCI		CHTA	RRETA			18. Mo	ther's Name ELS	e (First, Middle, SA IR		Surname) FERRAI	DEC.	1	
ary	should be f and Menta is marked aumatic ev		19a. Informant's Name/Relation			IKKEIA	19b Mailin	g Address (Stree	t and Num							
	2 H Z H		MARIA DEL CAR	MEN 1	ROMERO REMERO / W	/IFE		KENNEDY				-		.ip 000	9	
ore	0		20a. Method of Disposition 1 Burial 2 X Crematic	n 3 🗆 🗈	Pamoval from Str	20b. PI	ace of Dispos	sition (Name of patory or other pl	- !		Date		ocation - City c	r Town	, State	
Baltimore,	t. Page tment o tant: If jury or		4 Donation 5 Other	(Specify)	lemoval nom Sta			CREMATO	i	8-18-	-2012	R1		Ε, Ν	<u>1</u> D.	
Ba	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.													
П			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complic t only one	cations that cause cause on each I	ed the death	. Do not ente	r the mode of dy	ing, such a	s cardiac o	r respiratory an	rest,			pproximate terval Between	
observe,	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a.				EART FAI	LURE					Or	nset and Death	
_	Examiner		resulting in death)		0.0000000000000000000000000000000000000	s a conseque	STERRISH STREET	DETA LOPE	erasum.					Ι,	IO THEFKC	
		ner	Sequentially list conditions, if any, leading to immediate	b.		s a conseque		REPLACEN	ENT						LO WEEKS	
	uted Id	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	5 .	PROSTE	ETIC V	VALVE 1	ENDOCARI	ITIS	WITH	AORTIC	ROC	T ABSCI	SS	3 MONTHS	
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89	ss that the death certific igned by the attending be detached for use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23	Bc. If yes, outcom			E					23d. Date of de	eliverv		
Bô	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregnant 9 Unknown	t at time of de		Other (specify)	ncy				Month	Day	y Year	
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Re	Physician: The law this certificate has ral director, page 2		DIABETES M		rus, obe	SITY					perfo 1 Yes	rmed?	death?] No	
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on	endin eath. or: Aft the fur	fical		tigation	(Month, D	yay, rear)	injury	M 1 E	k? Yes 2				,			
Division of Vital Records,	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Certificate:	3 Suicide 6 Coul 4 Homicide deter	mined		njury - At hon etc. (Spec <i>ify)</i>	ne, farm, stree	et, factory, office		2	28f. Location (S City or Tow		d Number or Ru)	ıral Rot	ute Number,	
Ω	spital nours a neral I		29a. Certifier 1 X Certifyir	ng Physici	ian: To the best	of mv knowle	dae, death o		ne, date an	d place an	d due to the ca	iuse(s) a	nd manner as s	tated		
	he Ho in 24 h he Fui	Medical	(Check 2 L Medical	⊫xamıneı	r: On the basis of Practitioner: To	examination	and/or investig	aation, in my opin	ion, death (occurred at a	the time, date a	nd place	and due to the	Causels	s) and manner stated.	
-	Vyith To til		29b. Signature and title of certifi	er _				29c. Licens				29d. Dat	te signed (Mont	h, Day,	Year)	
	"		Miduel	1.2	à egu	illia	les 1	5100	1068	3479	7	<u>E</u>	5-15	2	2012	
			30. Name and address of person		ситилт со	мъ	961	0 010	יי סרום	זאז∆דיק	gn p	բարո	TA AGS) (00817	
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				f Maryland / De		nt of H	lealth :		/lental Hy			28	318
	Physicia	- m /	Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of	
and,	Medi	cal	Roger Dale Stephenson		-				Month August	12.	Year 2012	5:30	РМ
	Examir	ner	4a. Facility Name (if not institution, give street and num Holy Cross Hospital	ber)			Location of				y of Death		
	Funeral			7. Age (In yrs. last birthda	y) If Unde	r 1 Year	Spr:	24 Hrs.	8. Date of Birt	th	gomer g. Birthp	y lace (State or	r Foreian
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	and show at	o	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		l		bept. 2	1, 1950		Od. Inside Cit	v I imits
	Maryla 28a-f etified	Director	MD Montgomery	Silv	er Spi	ing						1 🗌 Yes	
	h the		10e. Street and Number		10f. Zip	Code				10g. Citizen of	What Coun	try?	
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003	urs aft :ural", al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Da		1 Tyes	2 🔼 No	Specify:			Specif	, White	9	
15-	72 ho n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gi	edent's Usu	rk done d		of worki	ng	16b. Kind of E	Business/Ind	ustry	
212	within giene.		Elementary/Secondary (0-12) College (1- 5-	4 Or 5+1	DO NOT use	,	ance (& Per	sonne1	Georg	e Wash	ington	Ibiv.
pu	tal Hyg d oth event,		17. Father's Name (First, Middle, Last)						e (First, Middle,				
Maryland 21215-0036	uld be d Meni marke natic	욘	Maselle Stephenson				Barb						
Ma	12 shoulth and 27 is rate		19a. Informant's Name/Relationship (Type, Print) Barbara Byrd/Mother						Route Number			ode)	
Baltimore,	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Place of Dis		ne of			Date	20c. Location		vn, State	
ţi	tment tant: I tant: I jury o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Metropol:	itan C	rema	tory	Aug Ž0	1^{14} ,	Alexand	lria,V	A	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee,	NO1503 5	rancis 00 Uni	d Addres Vers	Collin	ins I	Funeral	Home I	nc. pring,	MD 20	0901
			23a/Par 1. Enter the disease, or complications that cannot have a cause on each cannot be seen that the cannot have a cause on each cannot be seen that the cannot have a cannot be seen that the cannot have a cannot be seen that the cannot be seen	sused the death. Do not e	nter the mod	e of dying	, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Betw	
	nysician/ Medical			Respiratory	Failu	ıre						Onset and D	eath
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876	ificate ng phy as the		IF FEMALE:										
9 ×	eath certifica attending pl	ian/I	23b. Was decedent pregnant 23c. If yes, outcome in the past 12 months?	ome of pregnancy irth 2 D Fetal death 3	Ectopic p	regnancy	,				te of deliver	*	
P.O. Box 6876	re dea the al	by Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregn 9 ☐ Unknown 9 ☐ Unknown	ant at time of death 5	Other (sp	ecify)				Mo	onth [Day Ye	ear
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/ita	ysician; is certific director,	To Be	examiner?	patient 2 ER/Outpati		Othor	ce of Death						
of	ig Phy ter this neral o		27. Manner of Death 28a. Date o			Bc. Injury	at		ne 5 🗌 Reside 8d. Describe ho				
ion	tendir leath. or: Af the fu	ifica	1 ☑ Natural 5 ☐ Pending (Month 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	, Day, Year)	М	work?	′es 2 🗆 I	No					_
Division of Vital Records,	I or Attendin safter death. Director: Aff d in by the fu	Certificate:	4 Homicide determined 28e. Place of	f Injury - At home, farm, s , etc. (S <i>pecify)</i>	treet, factory	office		2	28f. Location (St City or Town		er or Rural F	Route Numbe	r,
	to the hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifications of the funeral director, the funeral director.	edical	29a. Certifier 1 **Certifying Physician: To the be	at of my knowledge, deatl	occurred at	the time,	date and p	olace, and	d due to the cau	use(s) and man	ner as stated	i.	
:	the 24 H	Σ .	only one) 3 Certifying Nurse Practitioner:	of examination and/or inve	estigation, in n	av opinion	i, death acc	curred at t	the time date an	d place, and du	to the caus	e(s) and many	ner stated.
	2 \$ 2 5		29b. Signature and title of certifier			License		0 -	- 1	9d. Date signe			
	_	-	30. Name and address of person who completed cause	of death (Item 22a) (Time		ما ע	53	5)	August	14, 2	2012	
				Forest Glen		Silv	ver S	prin	g, MD 2	0910			
	Stat	٠ ا		gistrar's Signature					<u></u>				
	Registra	ı	AUG 10 2012 Sene	J p. 77"	· ·								

		•	For State Registrar	State of	Maryla	nd / Depa Cer	artmen <i>tificate</i>			and Me		giene Reg. No.	20	12	2831	(
	Physicia Medic		1. Decedent's Name (First, Middle Ruth Lillian	Smith							2. Date of Dea Month August	Day		Year	3. Time of Death 2:30 A	М
	Examin Funeral	er	4a. Facility Name (if not institution Berlin Nursi 5. Social Security Number	ng Home		last birthday)	E	erl	in If Under 2		8. Date of Birt		Word	cest	er	ian
	Director	L	188-12-7583 Usual Residence of Decedent 10a. State 10b. County	1 □ M 2 🖾 F	92	Yrs.	Months	Days	Hours	Min.	(Month, Day 18/1	920		Count	NJ	
	he Marylan or 28a-f sh ontified a	Funeral Director	,	rcester		erlin	10f. Zip	Code				10a Citi	zen of Wh		0d. Inside City Limi	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Meadow Dr	12. Was Decede		.S. 13. V		21	811 spanic Orig	jin? (Specit	fy Yes or No- can, etc.)		USA 4. Race	A - America	an Indian,	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maceo Stanley Smith, Jr State of Maryland / Department of Health and Mental Hygiene 2012 28320 1-For State Amend#4a, 28b, f per OctMEate 6204at PGH ELM Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Medical Examiner 0920 hrs August 6, 2012 Maceo Stanley Smith Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Avenue Fairhaven ave. Upper Marlboro Prince George's Midland 7. Age (in yrs. last birthday) 5. Social Security Number **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Davs Hours Director 150-62-0871 50 Nov. 26, 1961 1 X M 2 F New Jersey Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No ten 27 is marked other than "natural", or items 23a nr 28a-f shuv traumatie event, the Medical Examiner must be notified at once. **TMOOF, MD 21215-0036**Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Marvland Prince George's Upper Marlboro Director 10e. Street and Number 10g, Citizen of What Country? 20772 United States 4513 Myles Court Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White etc 2 X No Yes African 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: American ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Plummer Private 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Maceo Stanley Smith Katie Brewington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772Valerie Chandler-Smith - Spouse 4513 Myles Court Upper Marlboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State Aug. 15, 1 Burial 2 X Cremation 3 Removal from State Lee's Crematory 2012 Donation 5 Other Specify Clinton, Maryland 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, 20019 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and Mortical a Multiple Blunt Force Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the bunal Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed page. certificate ✓ Yes 2 No 1 Yes fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 this DOA Nursing Home 5 Residence 6 V Other: Scene 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Aug 6, 2012 Driver of SUV that left roadway Director: Pending 8:56 am 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Fairhaven ave. a determined (Specify) Local Street dland tur Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 7, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Dat 1 PG A 2" th 2" 2012 32. Registrar' Signal State DOME Registrar

			State of Maryland / Department of Health a	and Mental Hy	giene	
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	Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 2 F Months Days Hours	24 Hrs. 8. Date of Birtl Min. (Month, Day	h 9. Birth /, Year) Cour	place (State or Foreign htry)
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	. 5 6 8		29b. Signature and title of certifie 29c. License number	Z /	9d. Date signed (Month, E	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0/0/1	-10
			HIROV G. BISHAW NA BIIBGONS LODE	ZOAD LAN	HAM, RO 3	0706
1	Stat Registra	e ir	31. Date filed (Nonth Day Year) 2012 22. Registrar's Signature			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jen 6MINIC Medical 20) 4a. Facility Name (if not institution, give street and nur Examiner 4c. County of Death 4b Montgomer. 9. Birthplace (State of Foreign Funeral last birthday) If Under 24 Hrs. 8. Date of Birth Months Days Mir BAC Dado Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No omer 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Barbad items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No and Mental Hygiene.
is marked other than "natural", Black 3 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SAlesman MUC Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rober 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, walkorive Method of Disposition 20b. Place of Disposition (Name of 20c. Location ty or Town, State Date 1 Durial 2 Cremation 3 Removal from State જ 4 Donation 5 Other (Specify) 12012 Germantown 22. Name and Address of Facility LIC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading cause. Enter Underlying Examiner Dust to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the hirial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 2 perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Tes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

8511

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

NO NIPUSE

28323 State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Dep	artment of Health and N tificate of Death	, 0	erre g. No.	
	Dhysisis	· /	1. Decedent's Name (First, Middle, Last)	-	2. Date of Death		3. Time of Death
	Physicia Medic	cal	Walter C. Sutton Sr.		August	04, 201 ² 2 ^{ar}	1940 р м
	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
4	Funeral		Prince George's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hyattsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	orge's
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	larylar 8a-f sl ified	Director	DC Washir				1 X Yes 2 No
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	h with ns 23a nust k	Funeral	51 55th Street SE	20019		United Stat	tes
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	ind 2 s lealth im 27 her tra			Addison Rd Apt 30	2 Capito	l Heights,	MD 20743
Baltimore,	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		TE Band E E Gronation o E namova nom otate	natory or other place)	_m	Oc. Location - City or To	·
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	To the Hos within 24 ho To the Fun completely	≥	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 29b. Signature and Atte of certifier	death occurred at the time, date and pla-	ce, and due to the c	ause(s) and manner as st	ated.
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			For State Registrar	State of M	arylar	nd / Depa <i>Cer</i>	artment of F <i>tificate of L</i>	Health : Death	and Me		giene Reg. No		2	2832	4
	Physicia	n/	1. Decedent's Name (First, Middle, La	ast)		_			2	. Date of Dea			ar	3. Time of Death	
	Medic Examin	al	Georgia 4a. Facility Name (if not institution, given		₹.		Shade 4b. City, Town, or	r Location	of Death		9,	2012 . County of D		16:40 PN	Į M
	L Xaiiiii		9410 Jones Plac				Lan		or Bodin			rince (aes	
	Funeral Director			Sex 1 M 2 F 7. Ag	95	last birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birt (Month, Day an 19	h v. Year)	g.	Birthpla Country	ace (State or Foreign	
	land show dat	ţō	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	d. Inside City Limit	s
	e Mary r 28a-1 notifie	Funeral Director	Maryland Prince (Georges		Lanham							\perp	Yes 2 🗆 N	lo
	vith th	eral [9410 Jones Plac	~ e			10f. Zip Code 20706	6			10g. Ci	tizen of What U.S.		y?	
	death v items ier mu		11. Marital Status	12. Was Decedent I	ver in U.		Vas Decedent of Hi Yes, specify Cuba	ispanic Orio	gin? (Specify	Yes or No-		14. Race - A	mericar		_
920	flied within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2X If Yes, Give Year or Dates.	No	1	Yes 2X No			an, etc.)		Black, W Specify:	hite, et $^{ m Bla}$		
2-0	2 hour "natul edical	plete	15. Decedent's (Specify only highest g	Education			ent's Usual Occupa		t of working		16b. K	(ind of Busine			
Maryland 21215-0036	ithin 7 iene. r than the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. Do	O NOT use retired)				Hic	hland	НС	spital	
nd	filed wall Hyg	Be c	17. Father's Name (First, Middle, Last)			COOK		18. Mothe	er's Name (Fi	irst, Middle, i					_
<u>ya</u>	uld be d Ment marke natic e	To	John Wesley Fost			1					ilso				_
	age 1 and 2 should be file int of Health and Mental H t: If item 27 is marked of y or other traumatic ever		19a. Informant's Name/Relationship (Hattie L. Saunder	, ,	er)		g Address (Street a Jones P]						Zip Co	de)	
Baltimore,	Page 1 and nent of Heal ant: If item 2 ury or other		20a. Method of Disposition 1	Removal from State	20b. F	Place of Dispos cemetery, crem	sition (Name of natory or other place	e)	Date		20c. Lo	ocation - City	or Tow	n, State	
E E	9 9 E E		4 ☐ Donation 5 ☐ Other (Spec 21. Signature Funeral Service Licer	rify)	Re		tion Ceme			/2012		linton,	Ма	ryland	_
Ra	permit. Departr Importa any inji	/8	Signature di Funieral Service Licer	Youk	1		. Name and Addres							me	
			23a Part 1. Enter the disease, or cor shock, or heart failure. List only	oplications that caused one cause on each line	the deat	h. Do not ente	r the mode of dying	g, such as	cardiac or re	spiratory arre	est,		- 1	Approximate nterval Between	
1	Medical	17	Immediate Cause (Final disease or condition resulting in death)	a. Atheros			Cardiovas	scula	r Dise	ase				Onset and Death	
	Examiner	_	Sequentially list conditions,	b —	CONSCO	derice oij.									
	ed sit	Examiner	it eny, leeding to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	conse	renda of):									
	execut an and irial-tra	I Exa	that initiated events resulting in death) Last	Due to (or as a	consequ	uence of):							+		
09/	ate be	edical		d									+		_
200	n certific ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live Birth	of pregna	incy	Ectopic pregnanc					23d. Date of	delivery		
O. Box	the death by the atte ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant a			Other (specify)	<u> </u>				Month	D	ay Year	
7, T	res that signed I	þ	Part II. Other significant conditions	contributing to death b	ut not res	sulting in the ur	nderlying cause give	en in Part I						cause of death?	n
Vital Records,	v requi	Completed								24a. Was a		24b. Were	autopsy	findings available	
Yec Yec	The lavate have	Som								autop: perfor 1 Yes	med?	death'	o comp ? res 2	bletion of cause of	
<u>ra</u>	siclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho	ar.	h (Check onl	ly one)	***				4
OT <	g Phys er this eral dii	te: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatie 28a. Date of injur	у	ER/Outpatient 28b. Time of	28c. Injury	4 ∐ Nu at		5X Reside		Other (Sp.	ecify)		_
on	tendin leath. :or: Aft the fur	Certificate:	1X Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not	ne l		injury		Yes 2 🗀	No						
DIVISION	al or At s after o		4 Homicide determined				et, factory, office		28f.	Location (St City or Town		d Number or F	Rural Ro	oute Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	vsician: To the best of onliner: On the basis of example of the basis of example of the line of the li	amination	n and/or investi	gation, in my opinio	n. death oc	curred at the	time, date an	d place	and due to th	e cause	e(s) and manner stated.	ed.
	To t To t		29b. Signature and title of certifier	Lery	m		29c. License			2		e signed (Mor			
	5 _{5m}		30. Name and address of person who	completed cause of de	eath (Item	23a) (Time B		.0731	<u>_</u> .		Au	g. 10	201	2	_
			Christian Lefev	re MD 2112	F 5	Street	NW #603 V	<i>M</i> ashii	ngton,	D.C.	20	0037			
	Stat Registra		31. Date filed (Month, Day, Year) AUG 1 5	32. Revistra	r's Signat	ture .	Save)								
_															

Please Type Print in Plank Indialible/15/1/1 Enthure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 28325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT A. SINGLETON, JR. Medical August 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Forest Hill Harford 2422 Johnson Mill Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 6/1/1943 214-42-1649 Hours **Director** 1**X** M 2 □ F 69 PA 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Forest Hill 1 Yes X No 10e. Street and Number ō 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral 2422 Johnson Mill Road 21050 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian ō 1 Never Married 2 Married Black, White, etc. þ 1 Yes 2 No Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The filed within all Hygiene.
Ther than "h.
The Me (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Truck Driver and Mental Hygie is marked other Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert A. Singleton, Sr. Marguerite Jones other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 2422 Johnson Mill Road, Forest Hill, MD Department of Health ar Important: If item 27 is any injury or other trau Patty Letke/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 X Other (Specify ntombment Harford Mem.Gdn. 8/24/2012 Aberdeen, MD Signature of Juneral Ser 22. Name and Address of Facility Harkins Funeral Home, Inc. Delta, PA over Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Smallcell lung nset and Death Physician/ disease or condition ea(5 Medical resulting in death) Due to (or as a sons quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical attending phys IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed 1. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Natural 5 Pending injury filled in by the Accident
Suicide Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 2012. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahrani,510 Ashkan Upper Chesapeake Drive, Bel Air, Marvland 31. Date filed (Month, 3EP) 0 5 2012 32. B istrar's Signature State

Dr.

DHMH 17 Rev 06-2011

Registrar

	For State		State of N	/larylan		partment of ertificate of		and M	iental Hy			2	2832
	Registrar 1. Decedent's Nam	ne (First, Middle,	Last)			Tillicale of	Death		2. Date of De	Reg. Neath	No.		3. Time of Death
cian/ dical	Jennie T	ingle							August	13,	^{Day} 2012	Year	12:20P M
niner			give street and number) , Apt. 34			4b. City, Town, o		of Death			tc. County o		
	5. Social Security N			ge (In yrs. Ia	st birthday)	If Under 1 Year	If Under		8. Date of Bi	rth		g. Birthpl	lace (State or Foreign
	354-24-6	-	1 □ M 2 🛣 F	80	Yrs.	Months Days	Hours	Min.	June 2)	Counti C 11i r	ry)
o	Usual Residence of 10a. State	10b. County		10c. City	, Town or L	ocation						10	Od. Inside City Limits
Director	Maryland		lerick		Thur	nont							1 🔀 Yes 2 🗌 No
Funeral D	10e. Street and Nur					10f. Zip Code				_	Citizen of Wh		
	113 Easy	Street	, Apt. 34	Ever in U.S	. 13.	Was Decedent of F		ain? (Spe	cify Yes or No		Jnited 14. Race -		
by	1 Never Marr		Armed Forces 1 Yes 2 If Yes, Give			Was Decedent of H If Yes, specify Cub 1 ☑ Yes 2 ☐ No					Black,	White, et	tc.
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Be Cc	12					Bookkeepe	er			Ac	count	ing	
To B	17. Father's Name	First,Middle, La unk.)	Martinez						(First, Middle, Pavon	, Maidei	n Surname)		
	19a. Informant's Na	ame/Relationshi	p (Type, Print)		19b. Mail	ing Address (Street	and Numbe	er or Rural	Route Numbe	er, City o	or Town, Sta	te, Zip Co	ode)
	Kenric T		Son		8201	Blue Her							
		☐ Cremation	3 Removal from Stat	e ce	Rest Re	osition (Name of matory or other pla IVEN	ce)	Aug.	Ĭ7,		Location - C		
	21. Signature of Saf	5 Other (Seneral Service Lice		Mer	noria	L Gardens 2 Name and Addre esthaven		2012					Maryland
	10	-5	7/										MD 21701
l Examiner	Immediate Cau (disease or conditio resulting in death) Sequentially list con if any, leading to im cause. Enter Under Cause (usease or that initiated events resulting in death) L	nditions, nmediate rlying injury	b. Due to (or as			11c C	and	ces					Onset and Death
manage for .	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 g ☐ Unknown	nonths? No	d. 23c. If yes, outcome 1	2 Fetal	death 3	☐ Ectopic pregnand Other (specify)	су				23d. Date o		y Day Year
by P			s contributing to death	but not resu	Iting in the I	underlying cause gi	ven in Part I	l.	23e. Did t	obacco	use contribu	te to the	cause of death?
eted	DIQ	beter	5						1 🗆	Yes 2	No 3	☐ Proba	ably 4 🗆 Unknown
Completed		-							24a. Was			or to com	sy findings available pletion of cause of
De Co	25. Was case referre	ed to medical	<u> </u>			26 E	ace of Deat	th (Chack	1 🗌 Yes	2			No
0	examiner?	X Vo	Hospital:	ient 2 🗆 E	R/Outpatie	nt 3 🗆 DOA Oth			ne 5 Resid	dence	6 ☐ Other (Specifyl	
are:	27. Manner of Death 1 Natural	5 Pending	28a. Date of inju	ury 2	28b. Time o injury		y at		8d. Describe h			Specify	**************************************
Certificate:	2 Accident 3 Suicide	Investiga	ot be	iuny - At hom	ne farm etr	M 1 eet, factory, office	Yes 2		Of Leasting #	244		- D I D	Danish Alicante
	4 L Homicide	determin		c. (Specify)	, raini, ali	est, ractory, office			8f. Location (\$ City or Tow			ıı murai R	oute ivumber,
Medical	only one) 3	☐ Medical Exa	Physician: To the best of aminer: On the basis of furse Practitioner: To the	examination :	and/or inves	tigation, in my opinio	on, death oc	curred at t	he time, date a	and place	e, and due to	the cause	e(s) and manner state
	29b. Signature and t	title of certifier				29c. Licenso		12		29d. Da	ate signed (A	10nth, Da	ay, Year)
†	30. Name and addre	ess of person wh	no completed cause of o	death (Item 2	23a) (Type, F	Print) Thoma	,,,,,	, ,			1 7	- /·	n'Or
	115	1 5	har ma	6	50	Thomas	VA	Tha	6 500	A	, , , ,	47)	72 0

State Registrar

Hiren A Shan Date filed (Month, Day, Year) AUG 16 2012

65 Istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28327 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 Day Month 8 Physician/ 2012 Mollie A. Timmons 5:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7764 Patey Woods Road Newark Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) Director 213-24-1583 1 □ M 2X F Yrs. 4-8-1911 101 \mathtt{MD} Usual Residence of Decedent Ad Mental Hygiene. Ad Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Worcester Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7764 Patey Woods Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Spec B: lack 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tomato Industry Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H ည Amanda Blake Era Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rudolph Timmons/Son 7764 Patey Woods Rd, Newark, MD 21841 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) alvary 8-11-2012 Berlin, MD UM Cem 21. Signature of Funeral Service Licensee Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physiclan/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ate has been signed by the a page 2 should be detached 9 Unknown g 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical of Vital the funeral director, æ 26. Place of Death (Check only one) examiner? Other: 1 Tyes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27 Manner₂of Death 28a. Date of injury (Month, Day, Year) 28b. Time of after death.

Director: After the 28c. Injury at 28d. Describe how injury occurred 5 - Pending 1 Natural Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 5 City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title d 29b. Signature an H005241 30. Name and add person who completed cause of death (Item 23a) (Type, Print) 44 Old oc Blud Berlin onvav rebore 31. Date filed (Month, Day, Year) egistrar's Signature State 16 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 28328 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Thomas Martin Terry 17 7:10 August . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County 210 Sunbrook Lane Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-84-9327 Director 1 🛛 M 2 🗆 F 50 March 12, 1962 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland notified at Director Maryland Washington County Hagerstown 28a-f 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be r Funeral 210 Sunbrook Lane 21742 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n Was Decedent Ever in U.S. 14 Race - American Indian. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Retail Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unknown Hazel Davis Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Sunbrook Lane Hagerstown, MD 21742 Carroll Beachley-companion Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-22-2012 Mt. Olive Cemetery Mt. Airy, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death squamous cell Lung Cancer immediate Cause (Final Physician/ 3 Y-ears disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of,: Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Por in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the aid 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be det þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death?
1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation after death Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 124 hours after e Funeral Dires sletely filled in t Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/20/2012 D0068995 23a) (Type Print)
Hoperstown, ND 21740 30. Name and address of person who completed cause of death (Item 1130 opa

Registrar
DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28329 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 14^{Day} 2012 10:10P M Robert Lawrence Trachy, Sr. 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min (Month, Day, Year) 83 002**-1**2-8912 1 🛛 M 2 🗆 F 1/14/1929 NH Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA Cannon Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1X Yes 2 \(\sigma\) No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify Specify: 3 ☒ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working United States life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Defense Communications Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yvonne Desjardens Arville Trachy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cannon Dr., Ocean Pines, MD 21811 Jeanne Mills/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) \$unset Memorial Pk:8/20/12 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burband Funeral Home 108 William St., Berlin, HD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death NEUMONIA disease or condition resulting in death) ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Little Uniterlying Cause (Disease or injury that initiated events soulding in death), act Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TYPE I 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed?

Physician/ Medical **Examiner**

Physician/

Medical

Examiner

Funeral

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Baltimore, Maryland 21215-0036

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Certificate:

29a. Certifier

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25. Was case referred to medical	26. Place of Death (Chec	ck only one)
examiner? 1 X Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day, Year) injury work? M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 3 Certifying Nurse Practitioner: To the best of my kn		me, date and place, and due to the cause(s) and manner stated and the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Vila Jayar	トフルクエク	Q1:5 2612/

29d. Date signed (Month, Day, Year) 2012

ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

HEALTHWAY DRIVE, BERLIN, MD-21811 AYAL 31. Date filed (Mon

State Registrar

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within 24 hours after deau...

To the Funeral Director: After t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, Ruby W. Tucker 2. Date of Death 3. Time of Death Physician/ August 13,2012 4:54A Medical ^{4a. Facility} Name *(if not institution, give street and number)* Hospital Washington Adventist Hospital **Examiner** 4b. City, Town, or Location of Death Takoma Park 4c. County of Death Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🛛 F Days July23 ,1925 NorthCarolina 246-26-1069 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location
Washington permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** D.C. 1 X Yes 2 □ No 10f. Zip Code 20018 10g. Citizen of What Country? U.S.A. 10e. Street and Number 3411 20th St. N.E. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: U.S.A. 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Center (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Walter ReedMedical Elementary/Seconday (0-12) Gellege (1-4 or 5+) Nurse Be 17. Father's Name (First, Middle, Last)
Andrew Taylor 18. Mother's Name (First, Middle, Maiden Surname) Annabell Whitley 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina Y.Tucker-Adams 1541 Channing St. N.E.Wash., D.C. 20018 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2012 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State FortLincoinCemet. Aug.20, Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 20001 21. Signature of Funeral Service License 22. Name and Address of Facility RobinsonFuneralHome1313 6th St.NWWash.,DC CC317 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ bro vano RM disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** eveten swe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မှ 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury accurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

8 44

State Registrar only one)

29b. Signature and title of certifier

HAMILTON ST 3415 31. Date filed (Month, Day, Year) AUG 1 6 2012 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

MD

29d. Date signed (Month, Day, Year)

HYATHUILL MD20782

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of Maryla		artment of H			giene Reg. No. 20	12	28331
			Decedent's Name (First, Middle, La.	st)				2. Date of De	ath		3. Time of Death
	Physicia Medio		Montrose Henr	y Tyree				Month 08	06	Year 12	1745 P ^M
	Examin	er	4a. Facility Name (if not institution, give	· · · · · · · · · · · · · · · · · · ·			Location of Death		4c. County		
	Funeral		Holy Cross Hosp: 5. Social Security Number 6. S		. last birthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Bir	th	9. Birthola	ace (State or Foreign
	Director		246-42-5784	□M 2 F 81	Yrs.	Months Days	Hours Min.	(Month, Da 7/4/1	y, Year)	Countr	Carolina
	how at	٦	Usual Residence of Decedent 10a. State 10b. County		City, Town or Loc	cation					d. Inside City Limits
	larylar	Director	MD Montgor		ilver S _l						1 X Yes 2 No
	a or 2		10e. Street and Number		-	10f. Zip Code		Τ	10g. Citizen of	What Countr	y?
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ဗို	ıral", d	ed b	3 ★Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify	Black	
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ַם בַּ	Illed will Hygi	Be	17. Father's Name (First, Middle, Last)	2 years			18. Mother's Nam	e (First, Middle,			
ylar	nd be Menta arked	은	William Henry				Roxie Th	nurman			
Mar	shou hand 7 is m raum		19a. Informant's Name/Relationship (7)			g Address (Street a					
o 3	I and 2 should be filed within 72 hours after death with the Mayland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Judith Tyree 20a. Method of Disposition	DAUGITTER	Place of Dispos	15 Nordi		trcle Si	20c. Location		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sr Department of Health a Important: If item 27 is any injury or other trai		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	cemetery, crem	atory or other place	9)			•	
ati	permit. P Departm Importa any inju once.		21. Signature of Funeral Service Licens	- 01	22	Name and Addres	s of Facility Was	shington	DC 200	11 M	aryland
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	olications that caused the de- ne cause on each line.	ath. Do not ente	r the mode of dying	, such as cardiac d	or respiratory an	rest,	1	Approximate nterval Between
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x 687	been signed by the attending p should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Da	te of delivery	,
P.O. Box	the at	ysic	1 Yes 2 X No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			Mo	nth D	ay Year
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VISI	's after death. I Director After this certificate ed in by the funeral director, pa	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		et, factory, office		28f. Location (S City or Tow	treet and Numbe	er or Rural R	oute Number,
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e Hos	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 ☐ Medical Exami	ner: On the best of my knowner: On the basis of examination of the best of examination of the best of	on and/or investi	gation, in my opinior	 death occurred at 	the time, date a	nd place, and due	to the cause	(s) and manner stated
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	-17 *		30. Name and address of person who de Dr. Ira Rabin 15	,	, , , , ,	,	wina Mi	20010			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1 9 2012 George Gerald Wilson August 8:10 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. (Month, Day, Year) Hours 079-18-0661 Director 1 XM 2 □ F 86 11/07/1925 NY or than "netural", or items 23a or 28a-f show the Wedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21042 10220 Fairway Drive hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗗 No 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlotte Start Andrew Joseph Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita M. Wilson - Wife 10220 Fairway Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/23/12 Hanover, MD remation Center of MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ∐ Yes ∠∟ 9 ☐ Unknown P.0. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 25200 vi ed cause of death (Item 23a) (Type, Print) Balto, Md 21204 N. Charles St. 6701 31. Date filed (Month. State Registrar

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	Physicia Medic	al	Herretta	Virgin	ia Walle		_					Month AUGUS	. D	b. 2	Year 0/2	3. Time of Death
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	Funeral		Doctors (ty Hospi		e (In vrs. la	st birthday)	Lanham If Under 1 Year	If Under 2	4 Hrs.	8. Date of Bir		rinc		orge's place (State or Foreign
	Director		232-38-6		1 🗆 M 2 🔀 F	1	86	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)		Cou	ntry)
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	the M	Funeral Director	10e. Street and Nun		000-80		1		10f. Zip Code				10g. C	Citizen of \	What Cou	ntry?
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000	rsafte rral", c Exan		3 X Widowed		If Yes, G Year or I	ive	NO		1 ☐ Yes 2 🕱 No	Specify:				Specify	W	hite
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2	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, L	ast)					18. Mother	r's Name	e (First, Middle,				
) Ja	ld be f Menta arked atic e	은	Samuel G	rover M	cCormick					Berth	na V	irginia	a Po	we11		
Maryiand	shou n and 7 is m raum	17	19a. Informant's Na			1 .		1	ng Address (Street							Code)
ນ໌	and 2 Healtl tem 2 other 1		Brenda Wa 20a. Method of Disp		om / Dau	gnt			Auburn A	venue,		verdale Date				own, State
0	age 1 ent of nt: If ii		1 🖾 Burial 2 4 □ Donation		3 Removal from	m State	, C	emetery, crer	natory or other place lasonic Ceme				l			Vest Virginia
paiminore	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Fu						2. Name and Addre							more Avenue
	gg E is bi	- 13	Long	Kiku	7									atts	vill	e, MD 20781
F	Phylician/		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition	rt failure. List o (Final	nly one cause on e	each lin	e.		er the mode of dyir Arrest	ig, such as c	ardiac o	or respiratory ai	rest,			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	1		o (or as	a consequ	ence of):								
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×	th cert	ian/I	IF FEMALE: 23b. Was decedent in the past 12			e Birth	2 Feta	Ideath 3	Ectopic pregnan	СУ					ate of deli	very Day Year
, DOX	he deat y the at ached fe	Physician/Medica	1 Yes 2 9 Unknown	No	4 ∐ Pre 9 □ Un		at time of c	leath 5 L	Other (specify)				:	IVIC		
7. L	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin E4 hours after death. To the Turneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	by	Part II. Other signif		ns contributing to		out not res	ulting in the u	underlying cause gi	ven in Part I.		1				the cause of death?
Records,	aw requas beer	Completed	Failure	to Thr	ive							24a. Was	psy		prior to c	opsy findings available ompletion of cause of
r L	: The licate h											1 \(\text{Yes}	ormed?		death? 1 Yes	2 🗆 No
N Ear	siciar s certif	To Be	25. Was case referr examiner? 1 Yes 2	No medical	Hospital:	Vinnat	iant 2 🗆	EB/Outnatia	nt 3 🗆 DOA Oth	lace of Death		ome 5 Res	idonco	6 □ Oth	er (Speci	5/1
5	ng Phy ter this neral o		27. Manner of Deat		28a. Dat	e of inju		28b. Time o injury		y at		28d. Describe				,,
00	ttendir death. tor: Af	Certificate:	2 Accident 3 Suicide	Investig	ation	a af lai	A h h	ma farm at		Yes 2 🗌	No	005 1	Ctooks		Dun Dun	al Deuts Number
DIVISION OF	al or At s after or Il Direct ed in by	Cerl	4 Homicide	determ			c. (Specify		reet, factory, office			City or To			er or Hun	al Route Number,
	ne Hospit n 24 hour ne Funera pletely fills	Medical	(Check 2	Medical E	xaminer: On the b	asis of e	examination	and/or inves	occurred at the time stigation, in my opini e, death occurred at	on, death occ	curred a	t the time, date	and plac	ce, and du	ie to the c	ause(s) and manner stated.
	Voith Con		29b. Signature and	title of certifier					29c. Licens		2		29d. D	Date signe		Day, Year)
	12 Jin		30. Name and addr	ress of berson v	vho completed ca	use of a	death (Item	23a) (Type.		155:	2_				08	,16,2012
	711		Kevin	1 Ert	Fan 8	118	6	ood a	Print) Luck Re	DAD, U	LAN	ham,	MO	20	070	6
	Stat Registra		31. Date filed (Mont	th, Day, Year)	012	Registr	ar's Signa		Med	,		/				
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			For State	State o	of Marylan		artment tificate			nd M	lental Hy	giene 2	012		283	334
			Registrar 1. Decedent's Name (First, Middle, Li	ast)		Cer	lincale	OI D	eain		2. Date of De		. 0 1 2	- _		
	Physicia		Hung Y. Wang	2007							August	lay 13	20 ^{Year}	,	3. Time of 7:15	A _M
	Medic Examin		4a. Facility Name (if not institution, given	ve street and nun	nber)		4b. City, To	own, or L	ocation of		agus -		ounty of Dea			
	- XCIIIII	<u> </u>	14150 Travilah R	oad			Rocl	kvil	1e			- 1	lontgo		У	
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs. la	ast birthday)	If Under 1			4 Hrs. Min.	8. Date of Birl (Month, Da	h	9. B		ce (State of	r Foreign
	Director			1 □ M 2 🛣 F	6	4 Yrs.	Wontho	Days	Tiouis	- 1	April			Ourriry,	Ch1	n <i>a</i>
	nd how at	7	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation					,		100	I. Inside Cit	
	faryla Sa-f s tified	Director	Maryland Montgo	merv	Ro	ckvi11	e								1 🗆 Yes	2 🗓 No
	the N	Ö	10e. Street and Number	J			10f. Zip C	Code				10g. Citize	en of What C	ountry	/?	
	n with	Funeral	14150 Travilah R	oad				208	50				U.S.A			
	deatl r iterr ner n		11. Marital Status	Armed Fo	edent Ever in U.S rces?		Vas Deceder Yes, specify	nt of Hisp / Cuban,	panic Origii , Mexican,	n? (Spe Puerto l	cify Yes or No- Rican, etc.)	14	Race - Am Black, Whi			
36	within 72 hours after death with the Maryland giene. Ier than "natural", or items 23a or 28a-f sho is, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	re	1	☐ Yes 2	X No	Specify:			Sp		siaı		
ğ	hours natur lical 6	Completed	15. Decedent's	Education		16a. Deced	ent's Usual (Occupat	ion			16b. Kind	of Busines			
21	in 72 e. nan "ı	duc	(Specify only highest of Elementary/Secondary (0-12)	grade completed, College (1	*	life. D(ind of work ONOT use re	etired)								
2	y with ygien her ti nt, the	Be C			2	Т	eache						Educa	tio	n	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)					18. Mother		(First, Middle,	Maiden Sui	mame)			
Ĕ	should b and Mer is mark raumatio		Ching Lin Yang 19a. Informant's Name/Relationship	(Type Print)		405 14-15-	A -1-1 (6		-1 \$1 !		nown	- O't T-	Ot-t- 1	Z:- O-	-1-1	
	12 sho Ilth an 27 is r trau		Hao R. Wang/Son	туре, гипу		1					Route Numbe			,	iej	1
<u>ē</u>	f Heali item 2		20a. Method of Disposition	**	20b. P	lace of Dispos	sition (Name	of	- !		ate		ation - City o		n, State	
Baltimore,			1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	፟፟ Removal from cify)		emetery, crem :ropo1i				3/16	/2012	A1exa	ndria	. V	'A	
ati	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Lice		, , , , ,		. Name and		_		eVol Fu			_		
<u> </u>	9 9 E 6	15	Kyan Mig	Millia	> MO1	202 10	E. D	eer	Park	Dri	ve, Gai	thers	burg,	MD	2087	77
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only			n. Do not ente	r the mode o	of dying,	such as ca	ardiac o	r respiratory an	est,		lr	pproximate	ween
-	Physician/	i v	Immediate Cause (Final disease or condition		lnoma of									С	nset and D	Death
	Medical Examiner		resulting in death)		(or as a consequ		_									
	- WF	Jer	Sequentially list conditions, if any, leading to immediate		static t		n, Bo	ne						-		
	ansit	Examiner	Cause (Disease or injury that initiated events	0										1		
	execu an an irial-tr	EX	resulting in death) Last	Due to	(or as a consequ	ence of):										
09	death certificate be executed the attending physician and ed for use as the burial-transit	dical		d										-		
189	ertifica ding p	Physician/Me	IF FEMALE:	23e If yes out	come of pregna	nev								-		
Box	requires that the death certifica been signed by the attending p should be detached for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	Birth 2 Feta	l death 3	Ectopic pre					23	d. Date of d Month	- 1		′ear
	y the check	nysi	1 ☐ Yes 2 X No 9 ☐ Unknown	9 Unkr		icatii 0 L	TOTHER (Spec	Sny/								
0.	that the	by Pi	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the ur	nderlying car	use giver	n in Part I.		23e. Did to	bacco use	contribute t	to the	cause of de	eath?
	uires	ed b									1 🗆 '	Yes 2□	No 3 🗆	Probat	oly 4 🗓 l	Jnknown
Š	law requires nas been sig e 2 should b	plet									24a. Was		24b. Were a	utopsy	findings a	vailable
Vital Records,	The ate h	Completed									perfo	rmed?	death?			2000 01
E E	cian: ertific ector,	Be (25. Was case referred to medical examiner?	I tana itali				T	e of Death	(Check						
<u> </u>	Physic this c	မ	1 ☐ Yes 2 🗶 No 27. Manner of Death		Inpatient 2				4 ∟ Nurs		me 5 X Resid			cify)		
0	ding l h. After funer	ate	1 X Natural 5 ☐ Pending	1 '	th, Day, Year)	28b. Time of injury	M 280	i. Injury a work?	at es 2□ N		8d. Describe h	ow injury o	ccurred			
SIO	Atten r deat ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 28e. Place	of Injury - At ho				2 2 1	_	28f. Location (S	treet and N	lumber or R	ural Ro	oute Numb	er,
Division of	al or safte		4 - Hornicide determine	buildi	ng, etc. (Specify))					City or Tow	n, State)				
	lospit t hour unera ely fill	Medical	29a. Certifier 1 X Certifying Ph (Check 2 Medical Exar	ysician: To the b												oner stated
	To the Hospital or Attending Physiciam within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	only one) 3 Certifying Nu				death occurr	red at the	e time, date		ce, and due to t	ne cause(s)	and manner	as stat	ted.	oratou
	2		29b. Signature and title of certifier	Luar	MD			icense n					signed (Mon			
	~		30. Name and address of person who	7	5 -	23a) (Time D		0055	522			Augu	ıst 13	, 2	.012	
			Robert H. Gerar		,		,	ad.	Silve	er S	pring,	MD 20	910			
	Stat	е	31. Date filed (Month, Day, Year)	06.0	to Associate Office of			,			. 0,					
	Registra	ır	AUG 1 6 201	12 Cers	egistrar's Signat	Mars	See !									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	State of Ma	ryland	/ Depa	rtment of H tificate of D	eaith an <i>eath</i>	id Me	ntal Hyg	eg. No. 20	12	28335
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Las LORRAINE	PR.	Wo	200,	1		2.	Date of Deat		2012	3. Time of Death
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or		Death		4c. Count	y of Death	
	Funeral		6205 Davis Blvd. 5. Social Security Number 6. Se	x 7. Age	In yrs. last	birthday)	Suitland If Under 1 Year	If Under 24 I	Hrs. 8	Date of Birth		e Georg	Ses lace (State or Foreign
	Director		172-28-3921	□м 2 XX .г	76	Yrs.	Months Days	Hours N	Min.	(Month, Day, 09/13/19	Year)	Count	ylvania
	nd how	5	Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Loc	ation			37/13/17	35		0d. Inside City Limits
	Maryia 18a-1 s	Director	Maryland Prince Geo	rges	Suit1	land							1 ☐ Yes 2 TXNo
	h tha Sa or Se or Se or Se	al Di	10e. Street and Number				10f. Zip Code				l0g. Citizen of		try?
	ath wil	Funeral	6205 Davis Blvd.	12. Was Decedent Ev	er in U.S.	13 W	20746 /as Decedent of His	spanic Origin?	? (Specify	Yes or No-	U.S.A	ce - America	an Indian
900	permit. Page 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hyglane. Important: If Item 27 is merked other than "natural", or Items 23s or 28a-f show may injury or other traumatic event, the Medical Examinational De notified at 2008.	ξ	1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	0	If	Yes, specify Cubar ☐ Yes 2 🕅 No	n, Mexican, Pu	uerto Ric	an, etc.)	Bla	ck, White, e	etc.
15-(72 hou n "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give k	ent's Usual Occupa ind of work done do NOT use retired)		working		16b. Kind of E	Business/Inc	lustry
212	within glane. er tha		Elementary/Secondary (0-12)	College (1-4 or 5+)		Mixolo	•				Servi	æ	
DE C	e flied ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)						•		faiden Surnam	ne)	
ڲۣ	2 should b lith and Mer 27 is mark r traumatic		Frank Grevera 19a. Informant's Name/Relationship (Ty	pe. Print)	Т	19h Mailin	g Address (Street a	Wanda I			City or Town	State Zin C	ode)
ž	nd 2 sh saith ar nn 27 ia er trau		Carla Woody (Daugter)				Wendy Ln. W				ony or rounn,	olato, zip o	
Baltimore, Maryland 21215-0036	. Page 1 ar iment of He tant: If Itan jury or oth		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		cem	etery, crem eteran '	sition (Name of atory or other place s Cemetery	08,	Date /30/20	012	20c. Location Cheltenh	am, MD	wn, State
Ball	permit Depart Import any in		21. Signs fure of Funeral Service Licens	" MO1555 h-0 W-l		22. 66	Name and Addres	s of Facility Kandria	Lee F Ferry	uneral H Rd. Cli	Home, Inc Inton, Mi	e. 0 20735	
	Medical Examiner	Examiner	23a. Parf 1. Enter the disease, or comparished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ne cause on each line.	A V (ice of):	The mode of dying			espiratory arre	st,		Approximate Interval Between
09/	cate be executed physician and the buriai-transit	edical Exar	Catase (Disease or Injury that initiated events resulting in death) Last	Due to (or as a of	consequen	ice of):							:
. Box 68760		ΣΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal d	eath 3	Ectopic pregnancy Other (specify)	/				ate of delive onth	ery Day Year ;
ds, P.O	quires that t en signed b suid ba date	þ	Part II. Other significant conditions of	ontributing to death but	t not resulti	ing in the u	nderlying cause giv	en in Part I.	_				e cause of death? nably 4 🗌 Unknown
Division of Vital Records, P.O.	: The law recate has be	Completed								24a. Was ar autops perform 1 Yes	med?	Were autop prior to cor death? 1 Yes	osy findings available inpletion of cause of
<u>ita</u>	sician certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatier	4 a 🗆 🗆	2/Outpation	Othe	ce of Death (ence 6 🗆 Oth	(2)(1)	20122-12-
5	ng Phy tar this nerai d		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	28	Bb. Time of injury	28c. Injury	at			w injury occur		
Ö	ttendir death. tor: Af the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				M 1 □	Yes 2 No	_				
<u>Š</u>	al or A a after i Dirac		4 Homicide determined	28e. Place of Injury building, etc.		e, tarm, stre	et, factory, office		281	City or Town		oer or Rural	Route Number,
	Hoapit 24 hour Funera taly fills	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	sician: To the best of m ner: On the basis of exa	y knowled amination a	ge, death o	ccurred at the time gation, in my opinio	, date and pla n, death occur	ace, and o	due to the cau	use(s) and man d place, and di	ner as state	ed. ise(s) and manner stated.
	To the I	Me		e Practitioner: To the				e time, date a		and due to the	e cause(s) and		tated.
			MAN chal	XX	ew	tam	DV	143	8		Hug	w	202012
	80.8		30. Name and address of person who o	SENTA	m	445	DEFEN	seth	WY	ANNI	APOL	Ma	DV 401
	Stat Registra		31. Date filed (Month, Day Year) AUG 2 1 20	32. legistrar	's Signature	. pa	ale		·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28336 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 16, Day 2012 Thomas Andrew Wyvill 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 9106 Grandhaven Ave. Upper Marlboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Director 218-38-5097 1**XX**M 2 □ F 71 July 5, 1941 Washington, DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🕅 No Maryland 1 Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A 9106 Grandhaven Ave. 20772 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ **3altimore, Maryland 21215-0036** 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Personnel Specialist EPA and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew J. Wyvill Rachel Coffren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9106 Grandhaven Ave. Upper Marlboro, MD 20772 Bonnie J. Wyvill (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) August 21, 2012 Suitland, MD Washington National 21. Signature of Juneral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death intaveriow. Immediate Cause (Final Myocardial Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last disear Stage 3 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ★ No Month Year 1 ☐ Yes 2 🕽 9 ☐ Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy perform Yes 2 No To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ဂ္ဂ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending ours after death. eral Director: Aft filled in by the fur 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1🚣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of c Mai 6. Cleampale

Box 68760

P.O.

Division of Vital

Registrar DHMH 17 Rev 06-2011 MW.

Name and address of person who completed cause of death (Item 23a) (Type, Print

Champaloup

D042049

Upper Manlbova

MID.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month us+ 20° Medical Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death Johns Hopkins more If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Director 227-42-1673 1 M 2 F 79 D2/18/1933 NC r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD lst. Mary's 1X Yes 2 ☐ No Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21349 Bristol Avenue 20653 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. à Never Married 2 Married 1 Yes 2 V No Maryland 21215-0036 1 Yes 2X No Specify: SpecifyBlack 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Depertment of Health end Mentai Hygiene. Importent: If item 27 is marked other then "ns any injury or other treumetic event, Iha Medis once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Wilcox Alberta Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Wilcox/Daughter 21349 Bristol Ave. Lexington Park, MD. 20653 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State Chesapeake Crem. 8/21/2012 Beltsville,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Briscoe-Tonic Funeral Home 38576 Brett Way Mechanicsville, MD. 20659 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Star Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or a consequence of): Hospital or Attending Physicien: The lew requires that the death certificate be executed buriel-transit and Due to (or as a consequence of): resulting in death) Last sate has been signed by the ettending physicien pege 2 should be detached for use as the buriel Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No a 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2/NO Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien. within 24 hours after death.

To the Funerel Director: After this certifice completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ၉ 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. 1800 Orleans 54. 31. Date filed (Month, Day, Year)

AUG 2 0 2012 32. Registrar's Signature State Registrar

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 28338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Patricia Winn 2012 6:25 Ам August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Nursing Home Prince George's Lanham Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Hours Subiaco 250-50-4863 1 M 2 K F Perth, June 18, 1925 Australia 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Riverdale 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6814 Ingraham Street 20737 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Andrew Tilson Helen Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Newfield Road, Glen Burnie, MD 21061 Carol E. Winn / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Marylan Veterans Cemetery | 8/22/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Linensee 22. Name and Address of Facility 4739 Baltimore Avenue Tonstance Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Multiple System Organ Failure disease or condition resulting in death) Metastatic Small Cell Adenocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Large Right Plaural Effusion, Coronary Artery Disease, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension, Anemia of Chronic Disease, Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? Paroxysmal Atrial Fibrillation 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check

Examiner Physician/Medical Hospital or Attending 24 hours after deam Funeral Director: Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) unly MO 8/10/2012 D24720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Rustagi, M.D., 6132 Landover Road, Cheverly, MD 20785 32. Registrar's Signature AUG 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 18 2012 Eric J. Williams 2025 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 577-62-9871 Director 1 1 M 2 | F Yrs. 66 1946 DC 18, Pege 1 end 2 should be filed within 72 hours efter death with the Maryland ment of Heelth end Mentel Hygiene. ent: If Item 27 is merked other then "neture!", or Items 23e or 28e-1 shot ury or other treumetic event, the Medical Eventher must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 St Yes 2 No Washington DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 619 K Street NE 20002 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Representative Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Wilbur J. Williams Mae Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Mays - Sister 619 K Street NE Washington, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. D24. 1 Burial 2 Cremation 3 Removal from State Depertment of Importent: If eny Injury or once, 4 Donation 5 Other (Specify) Harmony Cemetery 2012 Landover, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John lenat M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardia sulmin disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sepses Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hyperling ve To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensi Cardia My Due to (or as a consequence of): resulting in death) Last After this certificate hes been signed by the ettending physicien funerel director, page 2 should be detached for use es the burie Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 W 1 Yes 2 No 25. Was case referred to/medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Ninpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manny of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D-18895 19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAVE, STE340, TAKOMAPARD, MOBHRAK KARIM 7610 CARRULL 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 28340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Lynda Carol White 10:00P M Medical August 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9207 Surratts Manor Drive Clinton <u>Prince Georges</u> If Under **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. 579-72-3604 Director 1 🗌 M 2 🔀 F 58 Dec.1,1953 Wash.,DC 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified MD PG 1 XYes 2 No Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9207 Surratts Manor Drive 20735 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo þ Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 🗆 Widowed 4 🗀 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) <u>Registered Nurse</u> <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Richard Anita Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7070 Cradlerock Way #411 Columbia, MD, 21045 Department of Health a Important: If item 27 is any injury or other tra James L. White Jr/spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/24712 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition ears Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 morn 5 Other (specify) Pregnant at time of death Day Month ed by the a g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated page 2 should b 2 MNo 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 4 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death.

Director: Aft d in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral E Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) Signature and 29d. Date signed (Month, Day, Year) 00093 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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ANP-BC

Reynold 5

AUG 2 2 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security Number 6 579-28-4774	5. Sex 1 □ M 2 H F 7. Ag	e (In yrs. last t		Under 1 Year If Unonths Days Hou	nder 24 Hrs. 8 Irs Min. 0	. Date of Birth (Month, Day, X 4-25-19	9. B 22 Wes	rthplace (State or Foreign cuntry) T Moreland
aryland a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County			own or Location		·			10d. Inside City Limits 1 X Yes 2 □ No
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ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	2500 E Street N 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?		If Yes	20002 Decedent of Hispanics, specify Cuban, Mex	ican, Puerto Ric	Yes or No-	14. Race - Am Black, Whi	erican Indian, te, etc.
iin 72 hours ie. han "natur e Medical E	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	s Education		(Give kind	's Usual Occupation of work done during r OT use retired)	most of working	10	6b. Kind of Business	
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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		Leroy Thomas/ So 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	20b. Place ceme	e of Dispositio	itfield Ch on (Name of ory or other place) Cemetery	Date 1 Rd Date 14	e 20	m, MD 207 Oc. Location - City o Brentwood	r Town, State
permit. F Departm Importar any injur		21. Signature of Fundal Service Lice			22. Na	ame and Address of Fa		Lincoln	Funeral	Home
Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	one cause on each line	d the death. Do	o not enter the	e mode of dying, such	as cardiac or re	espiratory arrest		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequenc	e of):	eart Fo	i seask	2		
cuted and ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as	a consequenc	e of):					
ate be executed hysician and ihe burial-transit	cal	resulting in death) Last	Due to (or as a	a consequenc	e of):	_				
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bound by the funeral director, page 2 should be detached for use as the bound by the funeral director, page 2 should be detached for use as the bound by the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de		topic pregnancy her (specify)			23d. Date of de Month	elivery Day Year
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The law req ate has bee bage 2 shor	Completed	Hypertens Cerebrova	ion	ACCI	den	t		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ysician: s certifica director, p	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/		26. Place of I	Death (Check on	ly one)	ce 6 Other (Spe	
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the Hosp thin 24 hou the Funer mpleted fil	Medical	(Check 2 Medical Exa only one) 3 Certifying N	hysician: To the best of aminer: On the basis of e lurse Practioner: To the	xamination and	d/or investigati	on, in my opinion, deat n occurred at the time,	th occurred at the date and place, a	time, date and p and due to the ca	place, and due to the luse(s) and manner as	cause(s) and manner stated. s stated.
		29b. Signature and title of certifier	n			29c. License numb		290	d. Date signed (Mont	h, Day, Year)
65m		30. Name and address of person wh Tack Yu 15 31. Date filed (Month, Day, Year)	to completed cause of dispersion of the completed cause of dispersion of the completed cause of dispersion of the cause of the cause of	eath (Item 23a	a) (Type, Print)	Rd # 13	10, Ru	ckvill	e, MD	20850
Stat Registra	.C	AUG 1 4 201	2 Sent 2	ar's Signature	Sarke	<i>,</i>		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State o	of Maryland / Depa Cer	artment of F tificate of L		Mental Hygi Be	ene a. No. 20	12	28342
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Roslyn Olivia R	icks Williams			2. Date of Death Month August			3. Time of Death 02:35 A. M
, Marine	Medic Examin		4a. Facility Name (if not institution, give street and num	nber)	4b. City, Town, o	r Location of Death		4c. County of	of Death	
-	Funeral		Washington Adventist H 5. Social Security Number 6. Sex	ospital 7. Age (In yrs. last birthday)	Takon If Under 1 Year	ma Park If Under 24 Hrs.	8. Date of Birth	Mon	tgom	ery lace (State or Foreign
ì	Director		223-34-4388 1 □ M 2 X F	83 Yrs.	Months Days	Hours Min.	(Month, Day,) May 28,		Count	h Carolina
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation	1 .1			10	0d. Inside City Limits
	e Mary r 28a-1 notifie	Director	District of Columbia 10e. Street and Number	Wash	ington 10f. Zip Code		14/	g. Citizen of W	h -t Count	1 X Yes 2 No
	with the s 23a o	Funeral	5514 - 2nd Street, N.	W.	200	11		United		-
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv Year or Da	rces? If 2 M No e 1 ates. 16a. Deced	Yes, specify Cuba	ation	Rican, etc.)		- America k, White, e B1 a	ack
1215	ithin 72 ene. than "r he Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-12th grade	-4 or 5+) life, DO	kind of work done of D NOT use retired) Waitress	during most of work	king			al Hotel
nd 2	filed wi tal Hygie d other event, t	To Be (17. Father's Name (First, Middle, Last)		Waltress		ne (First, Middle, Ma	uiden Surname)		10001
aryla	nd Men marke matic	-	Wrapsy Ricks, Sr. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street	Veness and Number or Rur	sie Echl	_		ode)
, M	nd 2 sh lealth ar m 27 is ner trau		Kenneth Lamont Williams	(Son) 5514	- 2nd St	reet,N.W.	;Washing	ton,D.C	. 20	011
nore	age 1 a ent of H nt: If ite y or otl		20a. Method of Disposition 1	State 20b. Place of Dispo cemetery, cren Maryland	natory or other place	Aug.	18,2012	Oc. Location - C	•	
Baltimore, Maryland	permit. P Departm Importar any injur		21. Ignature o Funeral Service Incorporation	22	. Name and Addre	ss of Facility ${f R}$.	N. Horto	n Compa	ny M	orticians,
	40 = # 0		23a. Part 1. Enter the disease, or complications that of	caused the death. Do not ente	-				ngto	n,D.C.20011 Approximate
d	Physician/		shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	Massive	Str	ike 11	2 th	4		Interval Between Onset and Death
	Medical Examiner		6	or as a consequence of):	do	f by	Pur			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Due to (cause. Enter Underlying Cause (Disease or injury	or as $\mathcal I$ onsequence of):	66		~ / / /			
	ate be executed physician and the burial-transi	Еха	that initiated events C.	(or as a consequence of):					+	
09/	cate be executed physician and s the burial-transit	edical	d							
Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?		Ectopic pregnand Other (specify)	су		23d. Date Mon	e of delive th	ery Day Year
Division of Vital Records, P.O.	is that thighed by	þ	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause giv	ven in Part I.				e cause of death?
ords	require been si should	Completed					1 ∟ Yes 24a. Was an			pably 4 Unknown psy findings available
Rec	The law ate has page 2	Somp					autopsy perform 1 🗌 Yes 2	ed? de	rior to con eath? Yes	npletion of cause of
ta	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	/	- Oth	ace of Death (Chec				
of <	ng Phys ter this ineral di	te: To	27. Manne of Death 28a. Date	Inpatient 2 ER/Outpatien of injury 28b. Time of th, Day, Year) injury	t 3 DOA 28c. Injury	4 ∐ Nursing H y at	ome 5 Resider 28d. Describe how			
sion	vttendir death. ctor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At home, farm, stre	M 1 🗆	Yes 2 ☐ No	28f. Location (Stre	et and Number	or Rural	Route Number
Di <u>Xi</u>	Hospital or Attending I 24 hours after death. Funeral Director: After stely filled in by the funer			ng, etc. <i>(Specify)</i>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		or maran	Todato Harrison,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 X Certifying Physician: To the base only one) 3 Certifying Nurse Practitioner	is of examination and/or invest	igation, in my opinio	on, death occurred a	at the time, date and	place, and due	to the cau	se(s) and manner stated.
	To the within 2 To the comple	_	29b. Signature and title of sertifier	Pap.	29c. License	e number	· 1 29	d. Date signed	(Month, D	Pay, Year)
	99		30. Nameyand address of person who completed caus	se of death (Item 23a) (Type, P	rint)	0.15		,011	11.	112
	Sta	te	31. Date filed (Montl) (Day, Year) 32. H	egistrar's Signature	-m-y	WA.	1119-tu	nf	/ V V	TDG
	Registra		AUS 1 92012	1 back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Walker Physician/ Month oa va 08/03/2012 11:52 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Charles County Nursing & Rehab Ctr La Plata 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 579-50-6553 1 M 2 X F 75 11/16/1936 GA Usual Residence of Deceder 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director must be notified 1 X Yes 2 No MD Prince Georges Upper Marlboro 0 10e. Street and Number 10g, Citizen of What Country? items 23a Funeral 9827 Woodyard Circle 20772 AZU 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other the Office Cleaner Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ethel Shinholster Roger Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9827 Woodyard Cir., Upper Marlboro, MD 20772 Jannie Cobb / daughter Department of Health Important: If item 21 any injury or other tonce. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery U8/08/2012 Clinton MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature 6500 Allentown Rd - Camp Springs - MD 20748 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Diseane Physician/ disease or condition resulting in death) Medical consequence Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying Ause given in Part I.

Dean win thrombosis, Ceru, Canc 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has 2 No Yes 1 Tes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 욘 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending s after death. 1 Yes 2 No M Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 071199 O od address of person who completed cause of death (Item 23a) (Type, Print) aton Blvd, Gren Bwrnil, MD, 2106/ Di Josjin Vazha

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Amended #19a/	b. per funeral home Cer	tificate of L	112 cchd/t Death	nentai mygi D a Re	eg. No.	2 28344
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	17			2. Date of Death Month August	1 Day 2012	3. Time of Death 2 12:00 M
	Medic Examin		Eddie Lee 4a. Facility Name (if not institution, give str	Young reet and number)	4b. City, Town, or	r Location of Death	nugust	4c. County of De	
mark of the same			2911 Sandwich Dr		Waldor			Charles	
	Funeral Director	1	5. Social Security Number 403-20-7281 Usual Residence of Decedent	7. Age (In yrs. last birthday) M 2 \square F 8 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/30/	Year) C	kirthplace (State or Foreign Country) KY
	show dat	tor	10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
	Mary 28a-1 notifie	Director	MD Charles	Waldorf	Taor 7's Onda			0.000	1 X Yes 2 No
	h with the ns 23a or nust be r	Funeral C	10e. Street and Number 2911 Sandwich Dr		10f. Zip Code 20601			0g. Citizen of What (
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 12 Yes 2 945 to 17 Yes, Give 1 945 to Year or Date 1 970	Yes, specify Cuba		Rican, etc.)	Black, Wh	ack
215-(n 72 ho e. an "nat Medic	aldmo	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give k	ent's Usual Occup ind of work done o O NOT use retired)	during most of worki	ng	16b. Kind of Busines	ss/Industry
	ed within Hygiene.	Be Co		4+ Pi.	lot			US Air F	orce
and	and be filed whental Hyginarked oth		17. Father's Name (First, Middle, Last) John Young			18. Mother's Name	, ,		
Mary	2 should th and M 27 is man traumat		19a. Informant's Name/Relationship (Type	e, Print) 19b. Mailin	g Address (Street a	and Number or Rura	l Route Number,	City or Town, State, 225	Zip Code)
Baltimore,	e 1 and t of Heal If item 2 or other		Adrienne Battle, Da 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	emoval from State 20b. Place of Dispos cemetery, crem	sition (Name of natory or other plac	ce)	Date	20c. Location - City	or Town, State
Iţim	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice of the servic	Arlingto				Arlingto	n, VA neral Home
Ba	Depar Depar Impor any ir		ethic whit	9 //					MD. 20601
П			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do not ente				st,	Approximate Interval Between
-	hy i ian/ Medical	Š,	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):		onc	er.		Onset and Death
	Examiner		Sequentially list conditions, b	Due to (or as a consequence or).	_				
	sit sit	Examiner	if any, leading to immediate	Due to (or as a consequence of):					
	cate be executed physician and s the burial-transit	Exal	that initiated events cresulting in death) Last	Due to (or as a consequence of):					
260	the bur	edical	L d						
Box 687	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending place to the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Co. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year
s, P.O.	res that th signed by d be detac		Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause gi	ven in Part I.		pacco use contribute	to the cause of death? Probably 4 Unknown
of Vital Records,	e law requ e has been age 2 shoul	Completed by					24a. Was ar autops perforr	prior t med? death	autopsy findings available o completion of cause of ? Yes 2 \sum No
al B	ian: Th rtificat ctor, pa	Be C	25. Was case referred to medical examiner?		26. P	lace of Death (Checi	1 Yes :	Z S (NO)	res 2 🗆 No
Vit	hysic this ce al direc	은	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatier 28a Date of injury 28b. Time of		4 L Nursing Ho		ence 6 Other (Sp	ecify)
on of	ading Fath. rr. After the funer	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	work		28d. Describe ho	w injury occurred	
Division	al or Atte s after de il Directo		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, strebuilding, etc. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
_	ne Hospit in 24 hour ne Funera pletely fille	Medical	(Check 2 Medical Examine	sian: To the best of my knowledge, death one of the basis of examination and/or investing the practitioner: To the best of my knowledge,	tigation, in my opini	on, death occurred a	t the time, date an	d place, and due to the	ne cause(s) and manner stated.
0	With With With		29b. Signature and title of certifier		29c. Licens	F35		9d. Date signed (Mo	nth, Day, Year)
	Elso			mpleted cause of death (Item 23a) (Type, F					500
	Sta	te	31. Date filed (World), Day, rear)	MD 3500 Old Wash 32. Registrar's Signature	ington	Rd #102	Waldor	f,MD. 20	16.02
	Registr		AUG 2 0 20	12 32. Hogistrar's Signature	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:12 AM Pamela Gay YOUNG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1132 Beechwood Drive Hagerstown Washington Social Security Number 7. Age (In vrs. last birthday If Under ear If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Hours March 24 1951 ^{Corntry}iana Director 61 315-56-7029 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number o 10g. Citizen of What Country? 23a (Funeral 1132 Beechwood Drive USA or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Alumbaugh JoAnn James injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a William Young - Husband 1132 Beechwood Drive, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 8/20/12 Hagerstown, Marvland 21. Signature of Funeral Service Lig Minnich Funeral Home 22. Name and Address of Facility Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami the burial-transit and resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown g | I Inknown Part II. Other sig fi ant conditions o tributing to death but not result of name under ing 3e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 2 🗆 No After this certificate 1 🗌 Yes 25. Was case referred to funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 29a. Ce lifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death organised at the time, date, and died, the cause(s) and manner at stated. 29b. Signature and title of certifier 20045031 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 8190704

Registrar
DHMH 17 Rev 7/2009

State

legistrar's Signatu

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

12-06620

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arelle Amos		1- For State	f Maryland / L	epartme) <i>Certifica</i>			id Mental F		na Na	201	2 2831
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)						2. Date of Deat		Year	3. Time of Death
Medical Examin		LaRelle	Amos		1			Month Septembe			0257 hrs
	П	4a. Facility Name (if not institution, give s Johns Hopkins Hospital	treet and number)		1	ity, Town, or altimore	Location of Deat	:n	4c.	County of Death N/A	
Funeral		5. Social Security Number 6. Sex	7. Age (Ir	n yrs. last birth	day) If	Under 1 Yea	ar If Under 24Hr	s. 8. Date of Bir	th(MM/D	D/YYYY) 9. Birth	
Director	-	217-29-5646 1 M	2 X)#	22		lonths Day	s Hours Mil	07/22	/199		MARYLAND
kur	ŀ	10a. State 10b. County	100	c. City, Town o	r Location						10d. Inside City Limits
and show	ا _ة	MARYLAND BALTIM	ORE			ROS	EDALE				1 Yes 2 No
Maryli 28a-f	Director	10e. Street and Number			10	f. Zip Code		10	0g. Citize	en of What Count	try?
with the Maryland no 23a or 28a-f sho be notified at once.			PT 1C			212			U.S		
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. riced other than "natural", or items 23a or 28a-f ahe eit, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married	2. Was Decedent Eve Armed Forces? 1 Yes 2 X		If Yes, s	pecify Cubar	n, Mexican, Puerte	specify Yes or No- o Rican, etc.)		4. Race - Americ White, etc.	
ural",	≥ -	3 Widowed 4 Divorced If 0	Yes, Give Year r Dates: highest grade comple	ted) 16a. D		sual Occupa	specify: tion (Give kind of	work done		pecify: BLA(
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0036 within 72 ene. er than *	ᇍ	12yrs	lyr	В	ANK C					ANKING	
15-00 filed win I Hygien ed other		17. Father's Name (First, Middle, Last)						e (First, Middle, N			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than unatic event, the Medial	9	ANDREW G. AMOS JR 19a. Informant's Name/Relationship (Type		19b.	Mailing Add	dress (Stree		GRINAGE (1 Rural Route Num			Zip Code)
nore, MD 2121. ages 1 and 2 should be fill and the fill the Mental 1 is. If item 27 is marked other traumatic event,		Alisa Grinage/ Mot	her	1	2 Clo	verwoo	d Ct., l	Jnit 202	, Es	sex, Md.	, 21221
ore, Nes i and of Health If item		20a. Method of Disposition 1 X Burial 2 Cremation 3 ☐	Removal from State	20b. Place of cremator	Disposition y or other p		metery,	Date	20c. Lo	ocation - City or T	own, State
Baltimore, permit. Pages I an Department of Hec Important: If ite injury or other tr	1	4 Donation 5 Other Specify:		HOLY R			ETERY 09	9-10-12	BA	LTIMORE,	MARYLAND
Baltimore permit. Pages 1 Department of I Important: If) injury or other		21. Signature of Funeral Service Licensee	•		WILL 321	and Address	BROWN CO	MM. FUNI	ERAL	HOME-HA	ARFORD, P.A
Physician	+	23a. Part I. Enter the disease, or complicate failure. List only one cause on each		death. Do not							Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Gu	unshot Wound of								Death
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Box 6876 e death certificate the attending phy ed for use as the b	200	past 12 months?	Pregnant at time	2 [e of death 5	Other (Ectopic pregit	al icy	"	ionin De	ay Year
BO) he death	ÈL		9 Unknown					Loo Billio			(1.40
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tal Rec		25. Was case referred to medical			-	26.Place	of Death (Check	only one)	No.	1 🗸 Yes	2 No
of Vital ig Physician: fiter this certifineral director.	0	examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient	2 V ER/Outp	patient 3	DOA	Other Nursin	ng Home 5 F	Residenc	ce 6 Other:	
ding Phy. After th		27. Manner of Death	28a. Date of Injury (Month, Day Year) Sep 2, 2012	28b. Tir 0214 h	me of Injury		ry at Work?	28d. Describe h Subject shot		occurred	
SiOr Attend death. ector:		2 Accident 5 Pending Investigation					Yes 2 ✓ No				
Division of Vital Records, pital or Attending Physician: The law requir ours after death. The law for the certificate has been so filled in by the function page 2 should the certificate has been so filled in by the function of the certificate has been so filled in by the function of the certificate in the certificate of the certificate in the certificate of the certifica	۲1	3 Suicide 6 Could not be determined 4 ✔ Homicide	28e. Place of Injury (Specify) Outsid		n, street, fac	ctory, office b	ullaing, etc.	or Town, St 4815 The Alme	ate)		al Route Number, City
	ē '	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or	To the best of my kno	owledge, death	occurred a	t the time, da	ate and place, and , death occurred a	due to the cause	e(s) and	manner as stated	I. cause(s)
5 Wid 5 00	3	29b. Signature and title of certifier	d manner stated.			29c. License				ite signed (Monti	
Lan		J.M. 11				O.C.I	M.E.		Septe	ember 2, 201	2
- MA.	1	30. Name and address of person who com Jack Titus MD. Deputy Ch	pleted cause of death	, ,	W Baltin	more Stro	et Baltimore	MD 21223			
Stat	e 3	31. Date filed (Month, Day, Year)	32. Registrar's S		• • · · · · · · · · · · · · · · · · · ·	more one	.c., Daitimore	, 1410 2 1223			
Registra	ar	SEP 0 6 2012 &	who pl.	parke							· · · · · · · · · · · · · · · · · · ·
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month OS Physician/ orman Aurons 06:56 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Maryland Medical Center Funeral If Under 1 Year If Under 8. Date of Birth Birthplace (State or Foreign Country) Months **X** 1 🗆 м 2 🗆 F Hours Min MMar 18; 1973 39 **Director** 220-76-0595 Yrs ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits NA **Baltimore** MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? W.S.A. Funeral 21225 2706 Spellman Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after deat the and Mental Hygiene.
27 is marked other than "natural", or iten traumatic event, the Medical Examiner I 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No **Black** If Yes, Give Specify. Completed Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Self Employed Elementary/Secondary (0-12) College (1-4 or 5+) **Private** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

Brenda Aaronss ပ Norman Aarons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2706 Spellman Road, Baltimore, MD 21225 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau **Brenda Aarons** 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metro Crematory or other place Metro Crematory, Inc. Sep 04, 2012 Catonswille, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due in or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence or that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buris Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 g g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires been significant Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Nipatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 X Natural 5 Pending Division ours after death. eral Director: Al filled in by the fu Accident Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complet 3 🗌 29b. Signature and title of certifier 29c. License number 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baltimore, MD South 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 6 201

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Mai		partment of F ertificate of L			giene Reg. No. 20	12 28349
	Physicia Medic		1. Decedent's Name (First, Middle, La		EL			2. Date of De	ath 1 3 Ze	year 60c PM
	Examin		4a. Facility Name (if not institution, giv SEASONS HOSPICE @		HOSPITAI.	4b. City, Town, or	Location of De		4c. County	
	Funeral Director		5. Social Security Number 6.		In yrs. last birthday		If Under 24 H	drs. 8. Date of Bir lin. (Month, Da	th	Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a, State 10b, County		92 Yrs.			01/29	7/1920	MD
	larylan le-f sh	Funeral Director	MD BALTI		OWINGS					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	a or 28	١	10e. Street and Number	IORE	OWINGS	10f. Zip Code	ę		10g. Citizen of W	Vhat Country?
	ms 23	ner	3440 ASSOCIATED	WAY, #107	win II C	21117		(2) (7) (4)	USA	·
920	is filed within 72 hours after death with the Maryland tal Hyglane. Id other then "natural", or Items 23a or 28e-f show od other then "natural", or Items 23a or 28e-f show event, the Medical Evanirer must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba □ Yes 2 ☑ No	n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		e - American Indian, k, White, etc. WHITE
15-0	72 hou	Completed	15. Decedent's (Specify only highest g		(Giv	edent's Usual Occup e kind of work done o	ation luring most of v	working	16b. Kind of Bus	
Maryland 21215-0036	within glane. er ther		Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	DO NOT use retired) HOME	AKER		0	WN HOME
and		To Be	17. Father's Name (First, Middle, Last)		~ A ~			Name (First, Middle,	Maiden Surname)	
ڲٚ	a Mar		JOSEPH 19a. Informant's Name/Relationship (Type, Print)	SAMET	iling Address (Street a	MOLLI and Number or		er City or Town St	COHEN
			MARC APPEL / SO	N		-				MILLS, MD 21117
Baltimore,	2 = 2 = 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [20b. Place of Dis cemetery, cr	position (Name of ematory or other plac KODESH —	e)	Date		City or Town, State
altin	parmit. Pag Dapertment Important: any Injury o		4 Donation 5 Other (Spec	**	BETH I	SRAEL CONC 22. Name and Addres	. 09	/05/2012 OL LEVINS		MORE, MD
ñ	Par E		de is	Cé l		8900 REI	STERSTO	OWN ROAD	PIKESVI	ILLE, MD 21208
	Medical Examiner	8 (1)	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a complete to the complete t	erosc	leve c	g, such as card	io VA-SC	ula /	Approximate Interval Between Onset and Death
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	onsequence of):					
	ecuted and -transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for se a c	onsequence of):					
2	cate be axecuted physician and s the burial-transi	ical E	resulting in death) cast	Due to (or as a c	onsequence on.					
09/89	tificate ng phy e as the		IF FEMALE:	- u						
. Box 6	raquiras that tha death cartificate be axecuted baan signad by the attending physician and should ba detached for use as the burlal-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	у		23d. Date Mon	e of delivery nth Day Year
ds, P.O	quiras that t an signad b ould ba deta	ρ	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did t		bute to the cause of death?
ပ္ပ	Tha law ra cate has ba paga 2 sh	Completed						24a. Was auto perfo 1 ☐ Yes	psy pr prmed2 de	Vere autopsy findings available nor to completion of cause of leath?
Vital	sician: certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Trop	Othe	ace of Death (C			. h193010
5	ng Phy ter this inaral c	te: To	27. Manner Death 1 atural 5 Pending	28a. Date of injury (Month, Day,)	t 2 ER/Outpat 28b. Time (ear) injury	of 28c, Injury	at	g Home 5 Residence 1 Residence 1	dence 6 Other now injury occurred	
Division of	or Attending Physician: Tha iftar death. Director: After this certificate h In by tha funaral diractor, pag	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 380 Place of Injury		M 1 🗆	Yes 2 No	28f. Location (5	Street and Number	r or Rural Route Number,
<u>≥</u>	ital or / Irs aftar al Dire			building, etc. (Specify)			City or Tou	vn, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of my niner: On the basis of exal rse Practitioner: To the b	mination and/or inve	estigation, in my opinio ge, death occurred at the	n, death occurre ne time, date an	ed at the time, date a	and place, and due the cause(s) and ma	to the cause(s) and manner stated. anner as stated.
	ნ. <u>≱</u> 등 §		29b. Signature and title of certifier	6m	N	29c. License	58	72_	^	(Month, Day, Year) Y ZO 1 Z
	10v			BMO 6	th (Item 23a) (Type	Print) from the	n B	lud Ga	n Bare	4 2012
	Sta Registra		31. Date filed (Month, Day, Year) -	012 32. Sistrar's	Signature	rale				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Se PIEM RITA LYNN **AVERSA** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death ounty of De 05 MEDICAL CENTER W501 Social Security Number If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Davs Hours Min. Country) Director 214-66-7104 1 🗆 M 2 🗓 F 58 09/22/1953 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f shov any injury or other traumatic evant, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No BALTIMORE MD TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 FLORIDA ROAD 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced Specify. WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OPERATING ROOM TECHNICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MANSTOF BERNICE FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWSON, MD THOMAS AVERSA/HUSBAND 3 FLORIDA ROAD, 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY 09/05/2012 FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami To the Hospital or Attanding Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year ☐ Yes 2☐ No. 9 Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfort 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🖺 No Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Rive egistrar's Signatu State Registrar

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	1	State of Maryland / Department State For State Registrar State Of Maryland / Department Certificate		ental Hyg										
Physician /Medical	ı	Decedent's Name (First, Middle, Last) GLADYS AUGUSTUS		2. Date of Deatl Month AUGUST	30, 2012 3. Time of Death 30, 2012 5:16p									
Examiner	ľ	FUTURECARE @ IRVINGTON NURSING CENTER B.			4c. County of Death									
Funeral Director		5. Social Security Number 214-40-2830 Usual Residence of Decedent 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) Months 7. Age (In yrs. last birthday) Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 7–29–19	Year) 9. Birthplace (State or Forei Country) VIRGINIA									
ined within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show but, the Myster Expriner must be notified at Completed by Funeral Director	1	10a. State			10d. Inside City Limi 1 √ I Yes 2 □ N									
with the Man a or 28a-f sh be notified Director	-	10e. Street and Number 10f. Zip		10	Dg. Citizen of What Country?									
ral", or items 23a or 28a-f show Exarcitivat must be notified at 1 by Funeral Director	1	5920 WINNER AVE. 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ XNo If Yes, Give Year or Dates: 1 □ Yes	21215 dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Fi	cify Yes or No- lican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: BLACK									
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f Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, trainfallical To Be Completed	ם 1	17. Father's Name (First, Middle, Last) DAVID LEIGH	18. Mother's Name PEARL W	(First, Middle, M	BALTIMORE, CITY taiden Surname)									
alth and I			S (Street and Number or Rural NER AVE BALTI		City or Town, State, Zip Code) IARYLAND 21215									
ent of Hee nt: If item ry or othe	2	20a. Method of Disposition 1 Burial Ty Cremation 3 Removal from State 4 Donation 5 Owner (Specify) 20b. Place of Disposition (Naicemetery, crematory or of the complex	i i		20c. Location - City or Town, State BALTIMORE MARYLAND									
Department of He Important: If item any Injury or othoons once.		21. Signature of Funeral Service Licensee JONATIVAN D. HIBNER 2. Name ar	nd Address of Facility PHII	LIPS FU	UNERAL HOME, P.A. MORE, MARYLAND 2121									
ysician Medical aminer	by Physician/Medical Examiner	by Physician/Medical Examiner	23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode should or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a			Approximate Interval Between Onset and Death								
attending physician and for use as the burial-transit cian/Medical Examiner			Completed by Physician/Medical Ex	Completed by Physician/Medical Ex	Completed by Physician/Medical Ex	Completed by Physician/Medical Ex	by Physician/Medical Ex	cal Ex	ca: Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. One to (or as a consequence of): Due to (or as a consequence of):	MGREN			
Physician/Medi										lysician rived	Ilysiciai irricu	II y SI CIGIII I I I I I I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
be of								Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I.		acco use contribute to the cause of death? s 2 ☐ No 3 ☐ Probably 4 ☑ Unknow			
one Fundral prector: After this Sermicate has been strompletely filled in by the funeral director, page 2 should Medical Certification: To Be Completed							25. Was case referred to medical			prior to completion of cause of death? No 1 □ Yes 2 □ No				
this certifial director		examiner? 1 Yes 2 Xelo		e 5 Reside	nce 6 ☐ Other (Specify)									
al Director: After this of the funeral director by the funeral direction: To	2	2 Accident investigation M	Work? 1 □Yes 2 □No		w injury occurred eet and Number or Rural Route Number,									
To the Funeral Director: completely filled in by the Medical Certificat	-	28e. Place of Injury - At home, farm, street, factory building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred		City or Town,	, State)									
o the Fune ompletely fit		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurre	d at the time, da	ate and place, and due to the cause(s)									
2 00	2	29b. Signature and title of certifler	D71264	29	0d. Date signed (Month, Day, Year)									
V	1	30. Name and address of person who completed cause of death (Julian 23a) (Type, Print)		20 LAN	REL, MD 20707.									
State Registrar	3	SEP 0 6 2012 (Month, Day Year) 32. Registrar's lignature												

DHMH 17 Rev 1/2001

12-06468 Walter Brandt

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		- For State		ertificate	of Deatl	h		F	teg. No.	2.01	2000
Physicia	1/	Decedent's Name (First, Middle,Last)						2. Date of De Month	Day \	Year	3. Time of Death
Aedical Examin		Walter Jay	Brandt,	Jr.				August 2	7, 2012		0822 hrs
		4a. Facility Name (if not institution, give street	and number)		4b. City, T Easto		ocation of D	Death	Talbot	ity of Death	
	4	Easton Memorial Hospital	17.40				If Under 2	AUro R Date of R			nplace (State or
Funeral Director	ŀ	5. Social Security Number 6. Sex	_ " ' '	rs, last birthday)	Month:	s Days	Hours	Min		Foreign	n
Director		215–94–4405 1™ 2	F32		rs.			11/19	/1979	Cou	^{intry)} Maryland
b	-	Usual Residence of Decedent 10a. State 10b. County	1100 0	City, Town or Lo	ration						10d, Inside City Limits
ow any										1 Yes 2 X No	
Maryland 28a-f show	إذ	Maryland Caroline 10e. Street and Number	G	reensbo	ro 10f. Zip	Code			10g. Citizen of	What Coun	
Mary r 28a	9				101. 210				-		.,,
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	_ L	25625 Mockingbird Lan	e as Decedent Ever in	- II O T 10 1	Man Danada	216		? (Specify Yes or N		S.A.	can Indian, Black,
th wi	a		med Forces?					uerto Rican, etc.)		hite, etc.	an maian, Brasis,
er dea	Š	3 Widowed 4 Divorced If Yes,	Yes 2 X N Sive Year	0	Yes 2	No	specify:		Specia	fy: Whit	re l
rs aft ural"	<u>a</u>	or Date 15. Decedent's Education (Specify only high	s:	1) 16a. Dece				d of work done	16b. Kind of		
2 hou	<u>اڇ</u>		liege (1-4 or 5+)	during	most of wor	rking life.	DO NOT us	e retired)			
136 thin 72 hou te. than "na dical Ex	힐	12	N/A		Mecha	anic			Auto	Servi	ice
5-0036 ed within 72 tygiene. other than 'h M dical	Completed	17. Father's Name (First, Middle, Last)				1	8.Mother's I	Name (First, Middle	Maiden Surna	me)	
21215-003 build be filed within I Mental Hygiene, I marked other th	8	Walter Jay Brandt, Sr	•				Cindy	Α.	Mohr		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	_	19a. Informant's Name/Relationship (Type, Pr						er or Rural Route Nu			
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Baltimore, permit. Pages 1 at Department of Her Important: If ite Important: If ite	Ī	21. Signature of Juneral Service Licensee	MOO-732		2. Name and			Funono1	U. т.	D A	
© 50 4 5		the file			2041M	ount:	aln Ro	Funeral ad Pasade	ena, Ma	ryland	
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pe pe	Examiner	events resulting in death) Last Due to (or as a consequence of):									
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876 ifficat ng ph		3b. Was decedent pregnant in the	Live birth	2	Fetal death	3	Ectopic p	regnancy	Month	•	ay Year
Box 68 e death certifi the attending ed for use as	Physician	past 12 months?	Pregnant at time o		Other (Spe	cify)					
BO) te death the att	ڇ	9	Unknown				i an in Dark	220 Did	tobacco use co	ontribute to	the cause of death?
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ord w req as bee	Completed							auto			ompletion of cause of
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I Of	ᆰ	4 T Notes T	a. Date of Injury (Month, Day,Year) ug 23, 2012	28b. Time 1630 hrs	′ ′ 1		yatWork? ′es 2 . N	lunknown	how injury occ	Julied	
ivisior or Attend after death Director:	<u>ĕ</u>	2 Accident Investigation							(Ctract and No.	mbos or Pu	ral Route Number, City
Division of Vital Records, pital or Attending Physician: The law requir ours after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	Suicide Could not be	Be. Place of Injury -		treet, ractory	, office bi	ulluling, etc.	or Town,			
Di E Hospital 24 hours s Funcral etely filled		4 Homicide 29a. Certifier 1 Certifying Physician: To	Specify) Bathroo		oursed at the	o timo, da	te and place				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifu within 24 hours after death. To the Funceral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I	S	one) 2 ✓ Medical Examiner: On the	basis of examinati	on and/or invest	igation, in my	y opinion,	, death occu	rred at the time, dat	e and place, ar	nd due to the	e cause(s)
To the within 2 To the complet	Medical		anner stated.	_1		c. License					oth, Day, Year)
		1.6.,,,	/ /	, SA	_	O.C.1	И.E.		August 2	28, 2012	
		30. Name and address of person who comple	ted cause of death (Item 23a	(
HV			Medical Exami		. Baltimo	re Stre	et, Baltim	ore, MD 21223			
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's 819	nature ark	7						
Regist		SFP 0 6 2012 2	www p.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28353 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Valence Ε. Barker 2012 September 1:54Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silverside Edgewood Harford Road Social Security Numbe Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** (Month, Day Ye 1 🕅 M 2 🗆 F Days Hours 202-52-6745 75 Yrs **Director** Barbados Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Harford Edgewood 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 512 Silverside Road 21040 United States items 2 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify **Black** Specify: "natural", Completed 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. d other than " Harrisburg School life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor/Custodian District Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is markon any injury or net. pe Edna Barker Edwin Hoyt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Silverside Road, Edgewood, Maryland 21040 Natasha Jones / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Metro Crematory Inc. | 09/05/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a co Exami burial-transi Due to (o) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ó in the past 12 months? Month Day Pregnant at time of death Unknown the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? certificate 2 X No 1 ☐ Yes 2 ☐ No Yes or Attending Physician; funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work' hours after death. 1 🗌 Yes 2 No filled in by the Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier e of death (Item 23a) (Type, Print) 30. Name and address of person 10 V u, Mai Phas 1#206

State Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2200 M Martha H. Back August 25, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehabilitation and Nursing Center Sandy Montgonery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Days Min. 8977.82Y 1 □ M 2 🎗 F 91 washington. 577-28-2848 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 X No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18100 Slade School Road, Room 11 20860 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced Caucasian Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Accounting 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Brainard Howard Florence Bell and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau 7901 Greentree Road, Bethesda, Maryland 20817 Cindy Libby-Green/Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 09/14/2012 Silver Spring, MD 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Funeral Service License Katnin 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ burs Pheumonia disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner sphagia Sequentially list conditions, Examiner Du to (or as a cons y uence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Alzheimer's disease physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death a 🗌 Unknown Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disorder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural ithin 24 hours after death.

the Funeral Director: After perpeted filled in by the fur Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number attending physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 18100 Slade School Road Hoffman 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evon Tressie Brinegar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Haviede brai If Under 1 Year 8. Date of Birth Funeral If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 XF Min. 08/22/1922 North Carolina Director 90 217-16-0579 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XX Belcamp Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1201 Friars Wood Court 21017 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: white Specify: Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker in home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lester Fender Marjorie Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 1201 Friars Wood Court #302, Belcamp, MD 21017 Joan Wolff 20a. Method of Disposition 20b. Place of Disposition (Name of 9/5/2012 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial Gardens Bel Air, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Signature of Funeral Service Licenses Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Physician/Medical Examiner Due to (or as a consequence of that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death.
Funeral Director: After this certificate has been sign 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

ORIGINAL

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROONE Physician/ Month Da Year 022 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSP NORTHWEST MORE RANDALIS TOWN Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 6. Sex 8. Date of Birth Days August 22, 1 M 2 M **Director** Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MT 1 Yes 2 🗌 No altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral tillsdale 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ₩idowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21076 oleman MD onald 20a. Method of Disposition
1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 4 Donation 5 Other (Specify) Me 2017 Baltimore 21. Signatur Uneral Service Lic 22. Name and Address of Facility -uneral ahts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. THEROSCLEROTIC Immediate Cause (Final CARDIO VASCULAR DISEADE Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ó ☐ Pregnant at time of death☐ Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas After this certificate he funeral director, page 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29c. License number 480 EMBER 2012

State Registrar LOVA

ROAD

OUD

32. Registrar's Signature

RANDAUSTOWN

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOTNKN

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 03 2012 02:35P BERESON ALLAN BERNARD 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) N/A6 BOUTON GREEN COURT BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 214-30-6333 1 🛛 M 2 🗆 F 79 07/13/1933 MD 10d Inside City Limits 10b. Count 10c. City, Town or Location 1 X Yes 2 ☐ No BALTIMORE N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 6 BOUTON GREEN COURT USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) OWNER MASSEYS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERESON BERNICE NATHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 BOUTON GREEN COURT, BALTIMORE, MD 21210 PATRICIA BERESON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 09/5/2012 BALTIMORE HEBREW WOODLAWN, MD 4 Donation 5 Other (Specify) of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease or complication shock, or heart failure. List only one cau Immediate Cause (Final Sourit disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last

Physician Medical Examiner Examine

Physician/

Medical

Examiner

Funeral Director

or items 23a or 28a-f show miner must be notified at

i "natural", or item edical Examiner m

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Ith and Mental Hygiene.
27 is marked other than r traumatic event, the Mo

Department of Health Important: If item 27 any injury or other to

Director

by Funeral

Completed

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and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

and as the burial-tran use for page 2 s filled in by the funeral

Physician/Medical

Completed by

Be မှ

Certificate:

Medical

29b. Signatu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopia			23d. Date of delivery Month Day Year
Part II. Other significant conditions con		sulting in the underlying	cause given in Part I.		o use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown
V				24a. Was an autopsy performed?	
25. Was case referred to redical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 I	ER/Outpatient 3 🗆	26. Place of Death (Che Other: 4 \(\subseteq \text{ Nursing F} \)	ck only one) Home 5 Residence	6 ☐ Other (Specify)
27. Manuar of Death 1 V Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
29a. Certifier 1 Certifying Physi (Check 2 Medical Examin	cian: To the best of my knowner: On the basis of examination	n and/or investigation,	at the time, date and place, in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner state

narles Street # 210,

State Registrar

100

within 24 hours after death To the Funeral Director; A

DHMH 17 Rev 06-2011

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physic /Medi Exami

Funeral Director

Physician /Medical Examiner

ding Physician: The law requires that the death certificate be executed After this certific funeral director,

on or Vital Records, P.O. Box 68760,

Divisi	To the Hospital or Atten	To the Funeral Director:	completely filled in by the	/	Madical Cortifica
9		Re	S gis	ta str	
DHI	ИН 1	7 R	ev 1	/20	00

	1 - State Registrar		•	tificat					eg. No.	2012	2	835
n al	1. Decedent's Name (First, Middle, Last) Thomas S.	Bar	lan					2. Date of Deat	Day 23	Year 20\2	7	of Death
er	4a. Facility Name (If not institution, give street and number)				Location o				ounty of Death		
	BRIGHTWOOD NURSING HOME 5. Social Security Number 6. Sex 7. A	ge (In yrs. las	t hirthday)	If Under		If Under	_	8. Date of Birth		BALTIM 9 Birth		e or Foreir
	212-22-2871	84	Yrs. Months Days Hours Min.								Birthplace (State or Foreign Country) MARYLAND	
	10a. State 10b. County	10c. City, T	own or Lo	cation							10d. Inside	City Limit
runeral Director	MD. N/A	BAL	TIMOF	RE					1 Yes			es 2□N
ב ב	10e. Street and Number			10f. Zip				1	10g. Citizen of What Country?			
3	1 HAMILL CT. #23				2121				USA			
;	11. Marital Status 12. Was Deceder Armed Forces 1 □ Never Married 2 □ Married 1 ※ Yes 2 □	?	13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
2	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates			1 ☐ Yes		Specify:					ACK	
pe completed by	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give	dent's Usu kind of wo DO NOT u	al Occupa rk done c	ation <i>Juring mos</i>	t of worki	ng	16b. Kind	of Business/I	ndustry	
	Elementary/Secondary (0-12)	5+)	me. i	RETI		,			МТ	LITARY		
)	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle, I				
	THOMAS S. BARLAND, SR.					AN	NA G	ADDIS				
1	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Number	; City or T	own, State, Z	ip Code)	
	KAREN O. BARLAND (DAUGHT)	ER)	1 F	HAMIL	L CT	#23	BAL'	TIMORE,	MARY	LAND 2	1210	
	20a. Method of Disposition 1X Burial C Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL 20c. Location - City or Town, State 9-5-2012 BALTIMORE, MARYLAND											
21. Signature of Fune Service License JONATHAN D. HIBNER 2. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND											21217	
	shodk, of heart failure. List only one cause on each Immediate use (Final disease or condition resulting in death)	Immediate use (Final disease or condition									Between	
<u>ט</u>	Sequentially list conditions, if if y had y the list in a cause. Enter Underlying Cause (Disease or injury	4-1-	ience of): Lbetes Mellitus								20	2 242
enical Examine	that initiated events c.	s a consequer						يدز کوم			20	2912
3	d	ere 1	000	var.	نسلا	XY	1.30	CICAN	. •		4	712
r ii y si cidii / Mi		e pf pregnanc 2 □ Fetal de at time of deal	eath 3]Ectopic p] Other <i>(s</i> µ					23	d. Date of deli Month	very Day	Year
- 60 00	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown											
combined by	24a. Was an autopsy prior to death? 1 Yes 2 No 1 Yes										topsy findin ompletion o	gs availat of cause o
2	25. Was case referred to medical examiner? 26. Place of Death (Check only one)											
	1 ☐ Yes 2 ☐No Hospital: 1 ☐ Inpa		l/Outpatier			412 Nu		ne 5□Reside			cify)	
	27. Manner of Death 1 [A Natural 5 Pending investigation 3 Suicide 6 Could not be determined.] 28a. Date of Ir (Month, December 1)	ay Year)	Bb. Time o Injury	М		vat ⟨? Yes 2□	No	28d. Describe h	. ,		ral Route N	lumber.
eucal cermicanon.	4 Homicide determined building, 29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner	etc. (Specify) st of my knowled of examination	edge, deat	h occurred	at the tin	ne, date ar pinion, dea	nd place,	City or Town	ause(s) a	nd manner as	stated.	

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR.G931.9/6/2012, WS
State of Maryland / Department of Health and Mental Hygiene 28359 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1613 A Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Harford Havre De Grace 8. Date of Birth (Month, Day, Year) 01-03-45 If Under 1 Year | If Under 24 Hrs. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Director 67 Yrs DC .33-36-0307 Usual Residence of Decedent shov 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Baltimore XX Yes 2 No NA 10e. Street and Number 10f. Zip Code Apt.#201 10g. Citizen of What Country? Funeral 717 Druid Park Lake Drive 21217 USA ral", or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 IXYes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: "natural" 3 Widowed 4 X Divorced American 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA Master Sargeant Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvina Elmer Terry Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 E. Jeffrey Street Baltimore, Maryland 21225 Teresa Phillips-Sister permit. Page 1 and Department of Heali Important: If item 3 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔯 Burial 2 🗆 Cremation 3 🗀 Removal from State Crownsville VA Cem. 09-12-12 Crownsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Clay, Stg fford Michae Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

With the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 1 Yes 2 9 Unknown 2 No Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Date signed (Month, Day, Year) 29c. License number 811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sara Hickey Harford Memorial Hospital Havre de Grace, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per med cert C933 11/18/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Ko ber 4:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death tuan at Holy Cross Burtonsville Montgomen If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Hours Nov 18, 1919 Canada **Director** 216-01-8055 92 1 🕱 M 2 🗆 F Usual Residence of Decedent show oms 23a or 28a-f shorements and most be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10g, Citizen of What Country? Funeral 20904 3148 Gracefield Rd CL T-13 USA items ? filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White "natural", Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) । Hygiene. I **other than** " College (1-4 or 5+) Elementary/Secondary (0-12) 12 manager traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or cet. Robert F. Carter Amy Beatrice Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13400 Fairland Park Dr; Silver Spring, MD 20904 Mimi Carter - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) chronic renal disease Medical Due to (or as a consequence of) **Examiner** systotic heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed physician and strans delirium resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending plant of the season IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Yes 2 No g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

☐ Yes 2 🖾 No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral prints. 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 🗌 Yes 2 \square No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D59524 ulen 11/26/2012

State

Registrar

3110 Gracefield Rd; Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Loveen J. Puthumana;

SEP 0 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 28361 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Time of Death August 27, 2012 Medical Examiner Kelly Cowie 1925 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Mary Land Months Davs Hours Director 214-11-4255 1 M 2 XF Feb. 12,1975 37 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
fitem 27 is marked other than "natural", or items 23a or 28a-f show or traumatic event, the Medical Examiner must be notified at once. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2305 Harford Hills Road 21234 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes Specify: White 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 4 Social Worker Medical 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Davida M. Wargo Frederick R. Cowie ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Davida M. Cowie: Mother 2305Harford Hills Road, Parkville, Maryland 21234 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cremateriosther place) 8-31-12 Hanover, Maryland 4 Donation 5 Other Specify Center of Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel.P.A. 6009 Harford Road, Baltimore, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Madieni Death a.Probable Drug Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit AMENDED 23a, 27, 28a-f, per me, g934 12-6-12 sm X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Day 2 past 12 months?

Division of Vital Records, P.O. Box 68760.

e attending phys for use as the b the Hospital or Attending Physician: neral Director: death. within 24 hours af

To the Funeral I

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State Registrar

Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an autopsy performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 X No 5 Pending fd: 8-24-12 | fd 1:30 am 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2305 Harford Hills Rd. Parkville,MD.

Fd: Residence

29c. License number

O.C.M.E

2 _ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc

3 6 X Could not be Suicide

determined Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

30. Name and address of person who completed ca f de h (I 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signatur

24b. Were autopsy findings available

death?

1 🗸 Yes

29d. Date signed (Month, Day, Year)

August 30, 2012

prior to completion of cause of

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ August 5:45 ам Vasiliki Chrisafis 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 11514 Monongahela Court Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 226-76-1466 **Director** 1 □ M 2 🛣 F 80 01/01/1932 Greece Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11514 Monongahela Court 20852 Greece death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 þ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Culinary Hostess other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Bill Ferentinos Georgia Tsima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michel Chrisafis - Son 40164 Featherbed Lane, Lovettsville, Virginia 20180 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/04/2012 | Silver Spring, Maryland Gate of Heaven Cem. . Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Katsina 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

3 Months Immediate Cause (Final Physician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 X No 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending after death.

Director: Af 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completely filled in by determined 24 hours a Funeral L Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D67258 August 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9707 Medical Center Drive, #300, Rockville, MD 20850 J. Farrell, Nicholas 31. Date filed (Month, Day, Year) 32. Registrar Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Chui Cheuna 6:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6 Sex Birthplace (State or Foreign Country) 8 Date of Birth (Month, Day, Year) Davs 213-06-0027 Director 1 XM 2 TF 70 China ms 23a or 28a-f shov must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Howard Ellicott Citu 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8319 Academy Road 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give Completed 3 Divorced Specify: Year or Dates Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Painter Artistru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kin Chu Cheuna Lin Ying 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8319 Academy Road, Ellicott City, MD Lai Cheng, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If its
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 9/11/2012 Adelphi. MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OVA al tor Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Live Betal death 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy 1 Yes 2 9 Unknown Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? After this certificate has been situated the funeral director, page 2 should 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed's death? 2 10 No 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🛂 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number

State

Registrar

9901 medical center prist, Rockville, Manland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registra s Signature

Brim Carpenter

31. Date filed (Month, Day, Year) SEP 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28364 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 04 03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 319-78-1697 **Director** 1 □ M 2 🔀 F 26 03/19/1986 Illimis Usual Residence of Dec or 28a-f shov 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State 10d. Inside City Limits Director MD PG Hyattsville 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1761 Village Green Drive 20785 USA or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner thould be filed within 72 hours after de and Mental Hygiene. is marked other than "natural", or it sumatic event, the Medical Examine Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Private permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Not Available Rita Booe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita R. Booe 1761 Village Green Drive; Hyattsville, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Important; If it any injury or o once. 1 Burial 2x Cremation 3 Removal from State Chesapeake Crematory 9/12/2012 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services of Funeral Service Licenses 4594 Reech Road: Temple Hills, Maryland 20748 Enter the disease, or compl atio s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Approximate Interval Between Onset and Death eart failure. List only o cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ neumonia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year Unknown 9 Unknown by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page, performed? certificate 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 No Other: ျှ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer (Month, Day, Year) Natural Accident 5 Pending 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of certifie RESOOI MO

State

Registrar

DHMH 17 Rev 06-2011

eene St Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Randi

(Month, Day, Year)
0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Kurt Bayne Detwiler 09701/2012 1030р м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death
Allegany **Examiner** Western Maryland Regional Cumberland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NJ 8 Date of Birth **Funeral** Days 523-19-2736 09/13/1961 50 Director 1 🛣 M 2 🗆 F 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Allegany ms 23a or 28a-f s must be notified Frostburg 1 Yes 2X No 10f. Zip Code 21532 10e. Street and Number 10g, Citizen of What Country? 96 Main Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 🗌 Widowed 4 🔀 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Writer Literature Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Susan Compton George Warren Detwiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Cedar Street Jenkintown PA 19046 Lee Detwiler Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot emetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 9/6/2012 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 22. Name and Address of Facility Simplicity Crem & Fun Ser Signature of Furieral Service Licensee ThomasAllenPA 7090 Ridge rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ SEPTIC disease or condition Medical resulting in death) Examiner EUMON1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transii that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEPATO REVAZ Records, 1 Yes 2 No 3 Probably 4 Unknown ALCOHOLIC 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natural Manner of Death Medical Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After it (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: No the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier SEPTEMBER 1, 2012 Mam um 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Lamm 12500 Willowbrook Rd. Cumberland, MD, 21502 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John C. Doetsch Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Birthplace (State or Foreign Country) Year If Under 24 Hrs 8. Date of Birth **Funeral** Hours Months Days (Month, Day, Year) Director 215-42-1167 1 X M 2 □ F 70 Yrs. April 9. 1942 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinet must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director N/AMaryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1915 Letitia Avenue **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1965 Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 1967 Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+) Highwav Administration State Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Holthaus John C. Doetsch Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Doetsch, Wife 1915 Letitia Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 09/06/12 Baltimore, Maryland 21. Signature of Funeral Service Presee Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) omin Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day signed by the at id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been sig should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 : autopsy certificate 1 ☐ Yes 2 🗚 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: At 2 🗌 No Investigation 6 ☐ Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 Home Stimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 8:38 AM August Brian Dickens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village Montgomery 19223 Dunbridge Way ocial Security Numbe . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 470-48-1401 75 **Director** 1 🛛 M 2 🗌 F Yrs. March 15, 1937 United Kingdom Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Montgomery Village MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United Kingdom 20886 19223 Dunbridge Way within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) 12 other traumatic event, the chemist research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Dickens Florence Heaton 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19223 Dunbridge Way; Montgomery Village, MD 20886 Sabine Dickens - wife permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Si maturo Freeral Service Rona. 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ malignant liona disease or condition YELL Medical resulting in death) Due to (or as a cui sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E. ter Underplag Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? the 1 ☐ Yes 2 ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manual of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending M 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier August 27, 2012 MD D4308 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 9707 medical Center Drive #300 Rochville, no Soros, mo 31. Date filed (Month, Day, Year) State 6 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Cen	tificate of	Death			Reg. No.	
Physici Medical Exam			chael Di					2. Date of De Month August 2	Day Yea	3. Time of Death 2109 hrs
		4a. Facility Name (if not institution 3212 Walbrook Avenue)		umber)	4	b. City, Town, or Baltimore	Location of D	eath	4c. County o	
Funeral Director		5. Social Security Number 219-90-1608	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Day		Min	B/1976	9. Birthplace (State or Foreign Country) MD
/ any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location				·	10d. Inside City Limits
Aaryland 28a-f show 1 at nnce.	ctor	MD 10e, Street and Number	N/A			Balti	more		10g. Citizen of Wh	1 X Yes 2 No
th the Maryland 23a nr 28a-f sho notified at nnce.	Director	3212 Walbroo	k Ave. A	pt 14		2121	6		U.S.	•
3 72 hours after death with the Maryland n "natural", or items 23a nr 28a-f she al Examiner must be notified at mee	Funeral	11. Marital Status 1 Never Married 2 MM 3 Widowed 4 Div		2 No	If Ye	s, specify Cubar	n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	White	- American Indian, Black, , etc. Black
iours aft.	ed by	15. Decedent's Education (Spe	or Dates:		16a. Decedent	Yes 2 No s Usual Occupa st of working life	tion (Give kind		Specify 16b. Kind of Bus	
5-0036 led within 72 h Hygiene. other than "r	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4 or 5+)		ales	. DO NOT USE	remedy	N/A	\mathcal{F}
21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cor	17. Father's Name (First, Middle, ${\tt Unk}$	Last)	L				ame (First, Middle	Maiden Surname)	***
O 5 5 5 € [To B	19a. Informant's Name/Relations					et and Number	or Rural Route No	ımber, City or Towr	
nd 2		Ashley Diaz (lace of Disposit	ion (Name of cer		Date		Lto., MD2121 City or Town, State
Page Page ment in nt		1 Burial 2 Cremation 4 Donation 5 Other Sp	pecify:			Cremat	ory	8-24-1.	Baltin	more, MD
Balt permit. Depart Import injury		21. Signature of Funeral Service	N.Wa	lliam						Home PA ore,MD 21217
Physician Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.	aused the death. I		mode of dying,	such as cardia	ac or respiratory a	rest, shock, or hea	rt Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence of):						
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):	:					
ted 1 Insit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	:					
3760, ficate be executed g physician and s the burial - transit	n/Medical	UNPENDED	AMENDED			-				
A 44 CM 10	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live b		2 Feta	I death 3 [Ectopic pre	gnancy	23d. Date of o Month	delivery Day Year
Box 687 ne death certific the attending I	Physicial		known 9 Unkno		J Otne	er (Specify)			18	
ires that the signed by I be detach	Ď	Part II. Other significant condit	ions contributing to	death but not res	sulting in the un	derlying cause g	jiven in Part I.			oute to the cause of death? Probably 4 Unknown
of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should b	Completed							24a. Was	psy pr	ere autopsy findings available ior to completion of cause of
Vital Reco		25. Was case referred to medical				26 Blace	of Death (Che	1 Yes		eath? ✓ Yes 2 No
Vital hysician this cert	o Be	examiner?	(Unamital)	npatient 2 E	R/Outpatient		Oth		Residence 6	Other: Scene
on of \ending Phy ath. or: After the funeral of th	- I	27. Manner of Death 1 Natural 5 Pend			28b. Time of Inji 2102 hrs	' '	y at Work? ∕es 2 ✓ No		how injury occurre	-
Division spital or Attendin tours after death.	Certification:	3 Suicide 6 Coule	a not be	e of Injury - At hon		factory, office b	uilding, etc.		(Street and Number State) ok Avenue #14,	r or Rural Route Number, City Baltimore, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier (Check only 1 Certifying Pt	nysician: To the bes miner: On the basis of and manner s	of examination and						
FSFS	Ä	29b. Signature and title of certifie				29c. License O.C.N			29d. Date signed	d <i>(Month, Day</i> , Year) 2012
		30. Name and address of person		,				1722	<u> </u>	
St	ate	Donna M. Vincenti, MI 31. Date filed (Month, Day, Year)		ledical Exami gistrar's Signature			Street, Bal	timore, MD 2	1223	
Regist	rar	31. Date filed (Month, Day, Year) SEP 0 6 2	172 Dener	w 3.	parks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ EGRERT Month 2 0 1 2 MARY 1.50P. M D Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Manor Care Nursing Home Baltimore Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 Months Days Hours July 11, 1911 Director 217-34-9452 101 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A **Baltimore** 1XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3716 Roland Avenue 21211 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Specify: White XX Widowed 4 □ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Glenn Gall Mary Alice Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Egbert (Son) 3716 Roland Avenue Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 XX urial 2 Cremation 3 Removal from State cemetery, crematory or other place
Lorraine Park Cemetery 9/6/12 Balto. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licens 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Falling disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a cons re ence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Johns Diseans Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregp 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2. autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 2 410 Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? Natural injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MID D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. ENTAW STJUILE 208 BALTIMOIZE MD 2120 821 CA IMTIZAH. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

SEP 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04 01:52 AM seo 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213-58-1323 **Director** 1 🔀 M 2 🗆 F 60 05/25/1952 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 421 South Chapel Street 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1X Never Married 2 ☐ Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural" Completed 3 Wildowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Food Preparer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Joseph Ensor, Sr. Betsy Wanita Hagen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Norma Leehugh 58 Ridgemoor Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemeters Frematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date injury or 1 Durial 2 X Cremation 3 Removal from State 09/06/2012 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u>Center</u> of Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ unstable disease or condition Medical resulting in death) Examiner artery disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? certificate has performe Yes 2 No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: ဂ္ 1 ♣Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. AT2438946 I3 Sep 04 2012 Hootan. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hootan F. 201 East university parkway, Baltimore, MD Hootan Forghani-Union Memorial Hospital

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28371 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 30. 2012 Year Betty Jane Ehudin 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Montgomery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month, Day, Year) 109-14-5398 **Director** 1 M 2 XF Usual Residence of Decedent 11/26/1924 New York r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Silver Spring 1 🗆 Yes 2 💢 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3118 Gracefield Road. #508 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 end 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other treumatic event, the once. Bookkeeper Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaacs Estelle Raunheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Zinner, Son-in-Law 8112 Sea Water Path. Columbia. MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Thiloh Cemetery 19/2/2012 Woodlawn, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M016211 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physicien: The lew requires that the death certificate be executed Coronary Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Lung Cancer r this certificate has been sir aral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🕅 No Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) HOSpice ၉ 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death.

The Funeral Director: After this objectly filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖄 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0060634 August 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Bindu Joseph, M.D. Rockville, MD 20855

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) SEP 0 6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joan M. Flanegin 1 Month 10:25 PM Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartland Assisted Living Severna Park Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) May 25,1920 329-05-3644 Davs Hours Min Director 1 M 2 XF 92 Illinois "natural", or items 23a or 28a-f show edicel Examiner must be notified et permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other treumatic event, the Medical Examiner must be notified et. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Benfield Road 21146 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 ☐ Yes 2 X No 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary Legal/Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Miller Christina Halm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lolly Bonomi: Daughter 805 Tin Oak Road, Severna Park, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elmwood Township Cemetery 9-6-12 | Elmwood, <u>Illinois</u> 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service License michael 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director name of the completely filled in the completely filled in by the funeral director name of the completely filled in the com Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 $^<$ IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Thrombo ey topenia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy performed 1 🗆 Yes 2 🗆 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (S) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medica 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) ust- 31, 257531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterang 204 nucrsville 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of F tificate of L			giene 2 (112	28373
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Robert McClell;	an Fleming				2. Date of Dea Month	Dav	Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give str					Sept.	01, 2	012	13:45 P ^M
	Examin	er	707 Maiden Choice		3107	4b. City, Town, or	sville	eatn	4c. County	of Death timore	e Co
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 F	Hrs. 8. Date of Birth	1	9. Birthpl	ace (State or Foreign
	Director		290-20-0082 1 X Usual Residence of Decedent	M 2 □ F 85	Yrs.	Months Days	Hours	04/09/1		Countr	io
	and show	ğ	10a. State 10b. County	10c. Cit	y, Town or Lo	cation		01/07/2	.,,,,		d. Inside City Limits
	Maryi 28a-f otifiec	irect	MD Baltimore	2 (Catonsv	ille					1 ☐ Yes 2 💢 No
	th the 3a or t be n	Funeral Director	10e. Street and Number	-	0107	10f. Zip Code	0.000		10g. Citizen of \		*
	ath wi	nuel	707 Maiden Choice	e Lane Apt. 2. Was Decedent Ever in U.S		Vas Decedent of Hi	21228			ed Sta	
٥	ter de , or ite		1 Never Married 2 Married	Armed Forces?	4-	-		(Specify Yes or No- erto Rican, etc.)		e - America k, White, et	
22	urs af tural" al Exa	ted	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates. 196))	☐ Yes 2X No			Specify.	Whit	te
C.	72 hc n "na Medic	Completed by	15. Decedent's Educ (Specify only highest grade	completed)	(Give k	ent's Usual Occupa kind of work done of NOT use retired)	ation furing most of v	vorking	16b. Kind of B	usiness/Indu	ustry
717	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)		mmunicat:	ions		Fede	ral Go	vernment
Maryland 21215-0036	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle, M	Maiden Surname	e)	
Z	uld be I Men narke natic	F	Virgil M. Flemi				Cec		Bless		
Z	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The enth and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	j	19a. Informant's Name/Relationship (Type, Mrs. Joanne L. Step		1	g Address (Street a Casey Av		Rural Route Number,			
e,	1 and of Heal item		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of		Easton, N	20c. Location -		
baltimore,	e + + e		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	inoval nom otato	-	ns Cemete		/10/2012	Crownsy	.ille.	Maryland
žait	permit, Pag Departmen Important: any injury once,		21. Signature of Funeral Sarvice Livensee	7/				Singleton			
_		- 1	Mill C	M011						urnie	, MD 21061
	hysician/ Medical		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only the commediate Cause (Final disease or condition resulting in death)	caúse on each line.	Wer	r the mode of dying	g, such as card	ac or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequ	ience of):	las	rena	l dese	111		
d		iner	Seque tially list or ditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):			c my			
	cuted ind transi	dical Examiner	Cause (Disease or injury that initiated events c.								
	oe exe ician a burial-	ia E	resulting in death) Last	Due to (or as a consequ	ience of):						
00/	res that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit		d.								
700	certifi anding use a	Physician/Me	200. Was account program	e. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta	ncy	Fotonia amanana			23d. Dat	e of deliver	,
ממ	death he atte sed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d	leath 5	Other (specify)	у		Mo	nth D	Day Year
į	at the detack	Phy	Part II. Other significant conditions contri	ibuting to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e Did tob	acco use contr	ibute to the	cause of death?
, Ú	ires the signer of the signer	d by				, , ,					bly 4 🗆 Unknown
colus,	w requ	Completed						24a. Was ar	n 24b. V	Vere autops	y findings available
ט ט	The lar ate ha page 2	mo.						autopsperforr1 ☐ Yes 2	ned?	orior to compleath?	pletion of cause of
וומ	cian: ertifica ector,		25. Was case referred to medical examiner?	- to - to			ce of Death (C		- 100	L 103 Z	
>	Physic this c	은	1 Yes 2 No	spital: 1 lnpatient 2 l 28a. Date of injury	ER/Outpatient		4 U Nursing	Home 5 Reside			
5	rding th. t After e fune	cate	1. Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 🗆		28d. Describe ho	w injury occurre	ed	
2 .	• Atter er des ector by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre			28f. Location (Str		r or Rural R	oute Number,
<u>.</u>	intal or urs aft ral Dir illed in							City or Town	· /		
	Hosp 24 hor Fune etely f	Medical	(Check 2 \(\sum \) Medical Examiner:	an: To the best of my knowle On the basis of examination	and/or investi	gation, in my opinior	n, death occurre	ed at the time, date and	d place, and due	to the cause	e(s) and manner stated.
:	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 ☐ Certifying Nurse P 29b. Signature and title of certifier	ractitioner: To the best of m	y knowledge,	death occurred at the 29c. License			e cause(s) and m		
			 /* 	- word	NH	0	0020		9	14	1/2
	20x1		30. Name and address of person who comp	oleted cause of death (Item	23a) (Typer Pr	int)	ue C	i and I	Colon	1111	le MI
	-		31. Date filed (Month, Day, Year)	32. Aegistrar's Signatu	ale	1 Cho	al (any (atell	ton	7
	State	е	SEP 0 6 201	32. Aegistrar's Signatu	A.	a. W. J					6 1 4 4

			Please Type or Prin AMEND, IT State of Ma	nt in B EM#19 arvian	Black Ind 9a per d7 Beba	delible FH . 69 artmen	! Ink. 31.,9 1 of H	Ensure A 6/2012 ealth and N	III C WS Vien	opies tal Hv	Are aiene	Legible.	
			For State Registrar			rtificate					Reg. No	71117	28374
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Martin L. Gladge	V					1	Date of De Month ugust	Da	Year 2012	3. Time of Death 2 11:40 A M
	Examir		4a. Facility Name (If not institution, give street and number) St. Agnes hospital	,			Town, or timo:	Location of Death	1		40	c. County of Deat	th
	Funeral Director			e (In yrs. I	last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. [Date of Bird Month, Da	th y, Year 193	9. Birth Co	hplace (State or Foreign
	land w t		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation					_		10d. Inside City Limits
	e Mary a-f sho	ctor	MD	B	ALTI	MOR	E						1 Yes 2 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 2713 Hollins FERRY	Re	OAD		21	230				tizen of What Co	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11, Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	Ever in U.: No		Was Deced If Yes, spec 1 ☐ Yes		spanic Origin? (Sj n, Mexican, Puert Specify:	pecify o Rica	Yes or No n, etc.)	-	14. Race - Ame Black, White Specify:	
5-0	72 hor "natur dical E	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usua kind of wo	al Occupa rk done d	ation Juring most of wor)	king		16b. F	Kind of Business/	/Industry
Maryland 21215-0036	within jene.	Completed	Elementary/Secondary (0-12) College (1-4or	5+)		CHAI					Ac	itomot.	IVE
pu	e filed tal Hyg dother	Be C	17. Father's Name (First, Middle, Last)			11777		18. Mother's Nam	ne (Fir	st, Middle,	Maide	n Surname)	
7 <u>a</u>	d Ment d Ment narked natic e	To	19a, Informant's Name/Relationship (Type, Print)		10h Mailir	na Address	/Street s	CARR	16	Lute Numb	A City	RTER or Town State	Zip Code), 21.213
	nd 2 sh alth and 27 Is r r traur		19a. Informant's Name/Relationship (Type. Print) / Carolyn Gladney-Greene-Dau	ighte:	3633	3 RA		NN AVE		BAL			ARYLAND
ore,	es 1 al of Hea f Item r othe		20a. Method of Disposition 1 ☐ Bunal 2 ★Cremation 3 ☐ Removal from State	20b. P	Place of Dispo emetery, crea	osition (Nan	he of		Date		20c. L	ocation - City or	Town, State
altimore,	t. Pag rtment rtant: I		4 □ Donation 5 □ Other (Specify)	M	ETRO	CREIN	ATOR	y sales	10	2012	BA	LTIMORE	MARY JAND
Bal	Departiment Departiment Departiment Departiment Departiment Department Depart		21. Signature of Funeral Service Licensee		41	2. Name an	10 Addres	HGTS A		_ `		HORE M	712
	-		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death	h. Do not ent	ter the mod	le of dying	g, such as cardiad	or re	spiratory a	rrest,	noise ju	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition and the complication of the complication o	ation	s of F								Onset and Death 1 Week
S	/Medical Examiner		Hepatic										Years
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events					,					
760,	e be executed rsician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events c	a consequ	uence of):								
(687	ertificat ing phy e as th	Medi	IF FEMALE:										
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Feta	I death 3	⊒Ectopic po ⊒ Other <i>(sp</i>			_			23d. Date of de Month	livery Day Year
_	es that gned by be deta	by Ph	Part II. Other significant conditions contributing to death b	out not resu	ulting in the u	ınderlying o	ause give	en in Part I.					o the cause of death?
, Martin Records,	require	eted							-				robably 4 Unknown
~ ~	i: The law icate has b r, page 2 s	Completed			-					1 Yes	psy ormed? 2□N	prior to death?	utopsy findings available completion of cause of
Gladney, or Vital F	/siciar s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Popular	ent 2 🗆	ER/Outpatie	nt 3□ D0	Othe	26. Place of Dea er: 4 ☐ Nursing F				6 □Other (Spe	ecify)
Gladney Division or Vital	nding Phy sth. r: After thi e funeral c		27. Manner of Death 1 Natural 5 Pending (Month, Death of Line) 2 Accident investigation	ury	28b. Time of Injury		28c. Injun Work		_			ury occurred	saily)
Divis	tal or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of in building, e	ury - At ho tc. (Specifi	ome, farm, st	reet, factor	y, office		28f.	Location (City or To			lural Route Number,
	he Hospii in 24 hour he Funeri pletely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examina		rvestigation	n, in my o	pinion, death occi			, date a	nd place, and du	e to the cause(s)
	To t To th	Σ	29b. Signature and title of certifier	/ AAI	N DL L	29		e number				ate signed (Mon	
Ų,	1/1		30. Name and address of person who completed cause of o	death (Iten	レ / (D n 23a) (Type.	Print)	D583			1		gust 30,	
_	Q.		Jeffrey L. Seibel, M.D S	t Agn	ies Hos	spita.	1 900	Caton A	Ave	nue E	Balt	imore, N	ID 21229
- 1	Sta Regist		31. Date filed (Month, Day, Year) 32. Regist	rar's Signa									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygier	ne a a la	00075
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death		No. 2012	28375
	Physicia Medic		CHRIS GORDON		2. Date of Death Month SEPTEMBE	Day Year R 3 2012	3. Time of Death 7:37 A
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1.7.57 A
-			9007 CONTIENTAL PLACE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav)	HYATTSVILLE If Under 1 Year If Under 24 Hrs.		PRINCE GEO	
	Funeral Director		5. Social Security Number 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday) 7. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea APRIL 11	^{9. Birth} Cour, WAS	place (State or Foreign http:// SHINGTON, DC
	d tow	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Letter to the county	anation			
	larylar 8a-fst iffed	Funeral Director	, , , , , , , , , , , , , , , , , , , ,				10d. Inside City Limits
	the M	į	MD PRINCE GEORGE'S HYATTSV 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	
	h with	nera	9007 CONTIENTAL PLACE	20785	U	SA	
	r deat		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
Baltimore, Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 X Married 3 Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: BLA	
2-0	2 hour	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work	ina 16b	. Kind of Business In	dustry
72	ithin 7 ene. • than the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+) life. L	OO NOT use retired)		COUEDMEN	
<u>0</u>	iled w I Hygi other /ent, t	Be	17. Father's Name (First, Middle, Last)	RECTIONAL OFFICER 18. Mother's Nam	e (First, Middle, Maide	GOVERNMENT an Surname)	<u> </u>
ylar	ld be f Menta arked atic ev	오	CLIFFORD GORDON	VERA LEW			
Mar	shou h and 7 is m			ing Address (Street and Number or Rura			
<u>ق</u>	of Health and Ment of Health and Ment fitem 27 is marker r other traumatic		20a. Method of Disposition 20b. Place of Disp	CONTIENTAL PLACE		LC , MARILAN Location - City or To	
OE E	Page 1 nent of ant: If if ary or c		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		VERDALE, MA	
<u>a</u> ti	permit. Page Department Important: I any injury o			2. Name and Address of Facility ${f J}$.			
	20 5 6 8			7474 LANDOVER ROAL		LLE,MARYLA	AND 20785
			23a. Part 1. Errief the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of):				Olisar and Boath
	Examiner	L	Sequentially list conditions, b. END STAGE RENAL I	DISEASE			
_	sit si	nine	cause. Enter Underlying				
de	be executed sician and burial-transi	Exar	Cause (Disease or linjury that initiated events resulting in death) Last c. HYPERTENSION Due to (or as a consequence of):		<u> </u>		
20	thing Prysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	d				
2/20	rtificat ing ph e as th		IF FEMALE:				
POX 6	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Use Birth 2 Fetal death 3 1 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year
ă Č	the deay the a	hysi	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown	Other (specify)		(1,0,10,1	Say You
5	s that i gned b	by P	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	o use contribute to th	e cause of death?
g.	een sig				1 🗆 Yes	2 No 3 Prob	pably 4 🛭 Unknown
Records,	has by	Completed			24a. Was an autopsy performed?	prior to cor	osy findings available npletion of cause of
ř =	in: The		25. Was case referred to medical	26 Plans of Death (Charl	1 ☐ Yes 2 🛣		2 🗌 No
VITal	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check	me 5 X Residence	6 Other (Specify)	
0 '	ing Pri ffer th ineral		27. Manner of Death 1 🛣 Natural 5 □ Pending (Month, Day, Year) 28b. Time of injury	(28d. Describe how inj		
VISION	death death tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Tyes 2 No			
	al or A s after I Direc d in by		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta		Route Number,
	To the hospital or Atendang Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death (Check 2 🗌 Medical Examiner: On the basis of examination and/or investigations.	occured at the time, date and place, an	d due to the cause(s)	and manner as state	d.
	thin 24		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place	e, and due to the cause	e(s) and manner as sta	ited.
	= ≥ ₹ 8		D. S.	H006626		Pate signed (Month, L) $-6 - 12$	
	5	ł	30. Name and address of person who completed cause of death (Item 23a) (Type, F		1	2.2	
	9		KATHRYN RATANAVANICH 106 IRVING ST. 31. Date filed (Month, Day, Year)		GTON, DC 2	20010	
	Stat Registra	_	SEP 0 6 2012 Registrar's Signature	Kel			
			JET V LAIL WATER TO THE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		State	of Marylar		artment of tificate of		and M	1ental Hy	giene 2	012	28376
Physicia		1. Decedent's Nam Evelyn	e (First, Middle,	,						2. Date of De Month August	Dav	2012	3. Time of Death 5:00 A M
Medic Examin		4a. Facility Name (if	not institution,	-	mber)		4b. City, Town, Silver				4c. Co	unty of Death	1
Funeral Director		5. Social Security N 231–68–4	umber	6. Sex	7. Age (In yrs.		If Under 1 Yea Months Days	r If Under		8. Date of Bir (Month, Da	th	g. Birth	nplace (State or Foreign ntry)
	-	Usual Residence		1 LJ M 24 LJ F		ty, Town or Loc	ation			Sept.	10,194	8 Vir	ginia 10d. Inside City Limits
Marylar 28a-f sh otified	Director	MD	,	e George'			H ei ght's	3					1 Yes 2 No
ith the 23a or 3	ral D	10e. Street and Nur 6521 T.a	nber Icona St	reet			10f. Zip Code 20747				10g. Citizen	of What Cou	intry?
r death w	y Funeral	11. Marital Status		12. Was Dec	edent Ever in U.	S. 13. V	/as Decedent of Yes, specify Cul	Hispanic Ori	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White	
ours after tural", o al Exam	ted by	3 Widowed	4 Divorced	If Yes, Giv Year or D			□ Yes 2 🗓 N		:			ecify: Bla	
vithin 72 ho liene. Ir than "na the Medic	Completed	(Spe Elementary/Seco 11th	ondary (0-12)	t's Education at grade completed College (1		(Give k	ent's Usual Occu ind of work done O NOT use retired	during mos	t of worki	ng	16b. Kind	of Business/N	
d be filed v Mental Hyg arked othe itic event,	To Be	17. Father's Name (i		ast)				1		e (First, Middle, ounds	Maiden Surr		
2 should the and the a		19a. Informant's Na					g Address (Stree				-		*
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			position	3 ☐ Removal from		Place of Dispos	atory or other of	ace)	[Date	20c. Locat	ion - City or T	
permit. B Departm Importa any inju once,		21. Signature of Fur		censee A	wliup	22	Name and Addr	ess of Facilit	ty J.		kins F	uneral	Home, Inc.
Physician/		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or conditio	rt failure. List or Final	nly one cause on ea	caused the dea ach line. ardial			ing, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Sequentially list co	1	Due to	or as a consequence of the conse	uence of):							
cuted nd rransit	Examiner	cause. Enter Under Cause (Disease or that initiated events	rlying injury	thy									
ate be executed physician and the burial-transit	edical Ey	resulting in death) l	Last	Due to	(or as a conseq	uence of):							
	ΣΙ	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 S	months? X No	1 Live	nant at time of	al death 3 🛄	Ectopic pregnar Other (specify)	ncy			23d.	Date of delive	very Day Year
ires that the signed by Id be detac	ò	Part II. Other signif			eath but not res	sulting in the ur	nderlying cause o	given in Part I	l.				he cause of death?
e has been si age 2 should	Completed										psy ormed?	prior to co death?	opsy findings available ompletion of cause of
cian: The	Be B	25. Was case referre		Hoopitali				Place of Deat	th <i>(Check</i>	1 🗌 Yes only one)	2 X No	1 Yes	2 L No
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	cate: To	1 Yes 2 27. Manner of Death	5 Pending	28a. Date (Mon	Inpatient 2 of injury th, Day, Year)	ER/Outpatient 28b. Time of injury	28c. Inju	ıry at	2	ne 5 🗌 Resid			y)
al or Atten s after deal I Director; ed in by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Place	of Injury - At hong, etc. (Specify		et, factory, office		-	28f. Location (S City or Tou		mber or Rura	l Route Number,
he Hospit. nin 24 hour he Funera npletely fills	Medical	(Check 2 only one) 3	☐ Medical Ex ☐ Certifying I	Physician: To the bas aminer: On the bas Nurse Practitioner	is of examinatio	n and/or investi	gation, in my opin	nion, death oc	ccurred at	the time, date a	and place, and	due to the ca	use(s) and manner stated.
To t With To t		29b. Signature and t	title of pertifier	On-			29c. Licens				29d. Date siç		
3		30. Name and addre		ho completed cause, MD 980.		, , , , .	int)		llver	Spring		st 30,	2012
State Registra		31. Date filed (Month		₽ 2. R	egistrar's Signa	ture_				-1	,, <u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc 30 per dyr 9931 9-6.12 yt lygiene State of Maryland Department of Featth and Mental Hygiene Certificate of Death

Reg. No. 2012 State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 Physician/ Month 538M CATHER INE, AUTHR Medical 44 Facility Name (if not institution give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shock Trauma Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Hours Min. 213-28-2259 **Director** 1 □ M 2 🕱 F Usual Residence of Decedent zo Pennsylvania 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Baltimore N/A ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21230 USA 1718 South Hanover Street 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian Black White etc. permit, Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home unknown Homemaker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barnet Jenny Samuel Mazzurco 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Dover Rd. Pasadena, Md 21122 Rosemary Clark (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 08/31/2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee any in MOO - 73222. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. Mon 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Multiple Injuries Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner +EMORRHAGIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMIN Examine Due to (or as a consequence of): executed CARDIAL ARREST and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year detached the 8 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown COURR EXTREMITY PRHUME completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 **I** No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: 잍 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred, motor vehicle collision, passenser. 28c. Injury at within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury ☐ Natural ☐ Accident 5 Pendina work 1 Yes 2 No 26/2012 Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Spe Ann Arunde Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Praetitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific MD KES-001 121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT MOORE University of Maryland Baltimore, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6

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ndy Marie Gu		State of Maryland / Department of Health and Mental Hygiene 1-For State amend #8 Per FH C93/ff 12 2 2 3 7 6 Registrar Reg. No.
Physici edical Exami	an/	1. Decedent's Name (First, Middle, Last) Sandy Marie Guerriero 2. Date of Death Month Day Year August 29, 2012 3. Time of Death 0220 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Port Deposit 4c. County of Death Cecil
Funeral Director		5. Social Security Number 196-60-4213 6. Sex 1 7. Age (In yrs. last birthday) 32 Yrs. 1 Months Days Hours Min. 32 Yrs. Months Days Hours Min. 32 Yrs. 32 Yrs. Months Days Hours Min. 34 Yrs. 35 Yrs. 36. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Pennsy1van
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Total Residence of Decedent Total State Total Country
Box 68760, death certificate be executed the attending physician and defor use as the burial - transit	- 	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last INTRODED AMENDED 23a, 27, 28a-f, per me, g931 9-20-12 sm Pregnant at time of death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify)
P.O.	Be Completed by Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24c. Place of Death (Check only one)
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Fuoeral Director: After this certificate has been six completely filled in by the funeral director, page 2 should be	edical Certification: To	27. Manner of Death 1 Natural 2 Natural 3 Natural 4 Natural 5 Pending Investigation 3 Natural 5 Natural 6 Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed 6 Other: Scene 28d. Describe how injury occurred subject shot self 28d. Descr
Ø		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

Registrar

DHMH 17 Rev 06-2011

Registrar

10V

Muncaster Mill Rd..

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001

Bindu Joseph,

31. Date filed (Month, Day, Year)

D0060634

Rockville, MD 20855

August 31, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 28380 Certificate of Death 1. Decedent's Name (First, Middle, Last) A Month 2. Date of Death 3. Time of Death Physician/ Year 6 man 10 S103 W 50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11101 mon アレノハラ Ver Social Security Number 6. Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. May 18. Maryland 215-72-1301 40 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 11101 Slye Court 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 0 ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Landscaper 12 Self Employed other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Barbara Sills Melvyn E. Gelman 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sin Department of Health an Important: If item 27 is n any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvyn Emmanuel Gelman/Father 11101 Slye Court, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 08/31/2012 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. ratri 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ung Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performe 2 🗌 No Yes 2 N 1 Tes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the eleted filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 No 5015-1mficked 2053M AUD SO SOIS Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural City or Town, State) determined building, etc. (Specify) Home Val DVIDS Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one moome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KER MODME State SEP 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G931, 9/6/2012, WS

State of Maryland / Department of Health and Mental Hygiene 28381 For State Registrar Certificate of Death t's Name (First, Middle_Last) 2. Date of Death 3. Time of Death Physician/ £05 201 Medical Name (if not institution, give street and number, 4b. City Examiner County of De If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 24 Hrs. Birthplace (State or Foreign Country) Funeral Days Months 1 M 2 D F Kansas Director 508-32-5549 81 Jun 6, 1931 ence of Deceden Pege 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.

Sant: If item 27 is marked other then "neture!", or items 23e or 28e-f show ury or other treumatic event, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** Reisterstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 U.S.A. 6112 Deer Park Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married δ Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify: Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore City** Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Henderson **Humphrey Grider** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, MD 21136 6112 Deer Park Road, Robert A. Grider 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pege 1 Depertment of Important: If it eny injury or o Garrison Forest Crownsville Cem. 1 X Burial 2 Cremation 3 Removal from State 9/11/2012 | Grownsville, 4 ☐ Donation 5 ☐ Other (Specify) Md. . Signature of Funeral Service Licen 22 Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Softer the disease, or complications that caused the shock, or heart failure. List only one cause on each line. feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a ob equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physician end for use as the burlel-trensit Hospital or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year ete has been signed by the e page 2 should be detached t g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ours after death.

erel Director: After this certificete has I filled in by the funeral director, page 2: autopsy death? 2 | No. 1 Yes Yes Dite Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funerel D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of Signatur 29d. Date signed Day, Year) 8 0 2012 ath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Y SEP 0 6 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AUGUST Patrick Gerard Glenn 5:55AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES BALTIMORE N/AHOSPITAL **Funeral** 3. Social Security Number 219-66-6909 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min (Month, Day, Year) Director 1**X** M 2 □ F Yrs. 03/02/1958 54 Maryland ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he matical and injury or other traumatic event, the Medical Examiner must he matical and 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Mt. Holly St. 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12th Grade College (1-4 or 5+) Carpenter Local 101 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Glenn Annie Hurt 19a. Informant's Name/Relationship (Type, Print) ($ext{child}$) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207Lakeysha Glenn-McMillian 1131 Ingleside Ave. Apt#1, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Cem. 09/10/12 Crownsville, MD Funeral Service Licenses ਤੋਰੇਤਵਿਸੀਰੀ ਸਿੰਡ ਸਿੰਹੀਆਂ Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD Signat 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DILATED CARDIOM TO PATITY Medical Due to (or as a consequence of) Examiner BRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) signed by the a Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 2 🗌 Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one) the 29b. Signature and title of certifie 29c. License number ρ 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar AVENUE

BALTIMORE

2012

21229

MD

MD

CATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 8:16AM otember GELLER 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timpre HOSPILA N/A9 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min 216-36-7180 **Director** 1 □ M 2 🛣 F 73 07/19/1939 MD Usual Residence of Decedent 0 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7202 ROCKLAND HILLS DRIVE 21209 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. 3 Divorced 4 Divorced Specify: Completed WHITE Decedent's Education 16a. Decedent's Usual Occupation 95 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r SOCIAL SECURITY Elementary/Secondary (0-12) 12 College (1-4 or 5+) CLERICAL ADMINISTRATION Known Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ **JACK** ROSENBLOOM HELEN KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health au Important: If item 27 is any injury or other trau MARVIN GELLER/HUSBAND 7202 ROCKLAND HILLS DRIVE, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Denation 5 - Other (Specif 09/05/2012 BALTIMORE, MD HEBREW YOUNG MENS of Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD DA Part 1. Enter the disease, or conshock, or heart failure. List only ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Interval Between Disease Onset and Death Immediate Cause (Final Atherusc Hear! erolic Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HyperTension Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has autopsy perform 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 1 Natural 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V SINAI State Registrar

12	06490	
12.	·U049U	

12-06490 Marcus Brown-G	riffir		e of Maryland / Depa					lible.	
Maicos Biowii-O		1- For State		ertificate d		iu ivientai i		. 201	2 2020
Physicia		Registrar 1. Decedent's Name (First, Middle,L					2. Date of Death		3. Time of Death
Medical Exami		MARCU	S BROW	5/V- C	SRIFI	EIM	Month August 28,	Day Year 2012	1452 hrs
		4a. Facility Name (if not institution, of Howard County General			4b. City, Town, o	r Location of Deat	h	4c. County of Dea	ith
Euroral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24Hr	s. 8. Date of Birth	n(MM/DD/YYYY) 9. E	irthplace (State or
Funeral Director			XM 2□F 9	Yı	Months Da		_	Fore	
		Usual Residence of Decedent	A 2 7	,,			10 /	7 7 5 1	TVEW YOUR
w any		10a. State 10b. County		, Town or Loca		A			10d. Inside City Limits 1 X Yes 2 No
yland	햦	10e. Street and Number	2 HRC	(011	10f. Zip Code		I 10	g. Citizen of What Co	
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Feath and Mental Figuenc. Tent: If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	9810 SOF	-TWATER	WAY	210	946		US	A
tems 2	nera	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Ever in U Armed Forces?			ispanic Origin? (S in, Mexican, Puerto		14. Race - Ame White, etc.	erican Indian, Black,
ter dea			1 Yes 2 No	1	Yes 2 N	o specify:		Specify:	ZACK
2 hours after "natural", Examiner	d b	15. Decedent's Education (Specify	or Dates:		ent's Usual Occupa	ation (Give kind of e. DO NOT use ref		16b. Kind of Busines	s/Industry
136 thin 72 hc than "na tedical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	S/	Most of working life	e. DO NOT use ret	irea)	EDUCH	TION
5-00 ed wit fygien other	5	17. Father's Name (First, Middle, La	st)	111	00,00	18.Mother's Nam	e (First, Middle, M	aiden Surname)	
121 if be fill ental F arked	Be B	MARIZ 7	BROW	14		CECIE	H ROL	AMDA G	RIFFIN
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmitte event, the Medical	2	19a. Informant's Name/Relationship	(Type, Print) MOTHER ANNA ROWN A	7 995. Mailii	Address (Stre	et and Number or	Rural Route Numb	per, City or Town, Sta	te, Zip Code)
e, M and 2 Health item 2	ŀ	20a. Method of Disposition			osition (Name of co	emetery,	Date	20c. Location - City	or Town, State
MOF	ı	1 Burial 2 Cremation 3 4 Donation 5 Other Special	Kemovar nom State	crematory or o		1 DX 9.	-5-12	LANDOX	ER, md
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ŀ	21. Signature of Funeral Service Lic	7.		Name and Addres	s of Facility	well	EYNIEL A	LHAME
		Ulah)	Buch		2206	vilFa.	il Kil a	1850p	111/1/20194
Physician		23a. Part I. Enter the disease, or cor failure. List only one cause on		n. Do not enter	tne mode or dying	j, such as cardiac (or respiratory arres	st, snock, or near	Appro imate Inte <1 Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Epilepsy Due to (or as a consequence of	of):					Deatri
		Sequentially list conditions,	b						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of c.	of):					
sit sd	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
execut an and al - tra	<u>Sa</u>	X UNPENDED	d. X AMENDED #1,23a,	pt.II,	27, per me	e,g933 11	l-9-12 sr	n .	
760, cate be physic he bur	Med	IF FEMALE:	23c. If yes, outcome of preg	gnancy				23d. Date of delive	ry
Box 68760, e death certificate be the attending physicied for use as the buring	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of de	ooth -	etal death 3	Ectopic pregn	ancy	Month	Day Year
Box death he atte	ysic	1 Yes 2 No 9 Unknow		ع ا	other (Specify)				
O. Box 68760, that the death certificate be set by the attending physici detached for use as the burn	by P	Part II. Other significant condition	s contributing to death but not r	resulting in the	underlying cause	given in Part I.			o the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed b	Autism					1 Yes		obably 4 Unknown
aw req	Completed						autops perform	y prior to	completion of cause of
Rec The I	5						1 ✓ Yes 2		
ital	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ✓	ER/Outnatier		e of Death (Check	only one)	Residence 6 Oth	er.
of V ing Phys After thi funeral di	읽	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of		ury at Work?		ow injury occurred	
On centing sath.	ţ	1 X Natural 5 Pending 2 Accident Investiga			1	Yes 2 No			
VISI or Att after de Direct	Certification:	3 Suicide 6 Could no	ot be 28e. Place of Injury - At h	nome, farm, stre	eet, factory, office	building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Di spital hours a	8	4 Homicide determine 29a. Certifier	(openy)						
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for	Medical	(Check only Certifying Phys	iclan: To the best of my knowled ner: On the basis of examination a	_					
To with	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	I	29d. Date signed (M	onth, Day, Year)
		high	~		0.0	.M.E.		August 29, 201	2
	}	30. Name and address of person wh							
			Medical Examiner 900			Itimore, MD 2	1223		
Sta Regist		31. Date filed (Month, Day, Year) SFP 0 6 201	2. Registrar's Signa	ure					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AWRENCE HARVEY EPTEMBER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALSIMONE RANDALLKOWN HNOKAL Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) MARYLAND Director 215-80-0083 52 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1XXYes 2 ☐ No MARYLAND N/ABALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 1305 INGLESIDE AVENUE 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XXNo 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give 3 Widowed 4 Divorced Specify.BLACK Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12yrs SOCIAL SECURITY ADMIN 1yr IT SPECIALIST event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ HELEN OUINCE permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic REGINALD HARVEY injury or other traumatic J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 W. Franklin St., Apt 8P, 21229 Baltimore, Md., Helen Harvey/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State KING MEMORIAL PARK 09-08-12 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature - Service Service Name and Address of Facility
LLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
106 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Other (specify) Pregnant at time of death ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 Yes 2 No 1 🗌 Yes 2 🗆 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes ٩ R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of funeral 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural inlury work?
1 Yes 2 No 5 Pending Investigation Accident completed filled in by the 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 5 To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifi

6 2012

DHMH 17 Rev 7/2009

s of person who completed cause of death (Item 23a) (Type, Print)

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DYRS ROAD RAHDALLSTOWN MAR

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Wendell 9:10 am Everett Harsh, Sr. Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROSEDALE BALTIMORE FRANKLIN SQUARE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Months Min Hours 277 26 3616 1 🛮 M 2 🗆 F 80 Director 08/13/1932 Ohio Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Completed by Funeral 3543 Dahlia Lane 21220 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white and Mental Hygiene. is marked other than "natural", Year or Dates.1951-54 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Steel Mill Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Daniel Everett Harsh Ruth Isabell Mowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other traconce. 3543 Dahlia Lane Middle River Maryland 21220 Ruby Harsh (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem Gardens 9/8/2012 | Baltimore County Md. Funeral Service Li 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NON SMALL CELL LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami burial-transit death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as signed by the attending Id be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 X No 1 🗌 Yes 2 🗌 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 🗷 No Hospital Other: 1 🗌 Yes 1 Nanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completely filled in by determined To the Hospital Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar 3 🗆

ROBERT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

29b. Signature and title of certifi

FRANKLIN SQUARE PR

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D62373

BALTIMORE MO

09.05, 2012

21237

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Α. Hohman, Jr. Sept. 2012 9:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7846 June Drive <u>Pasadena</u> Arundel 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Director 216-24-9141 1**X** M 2 □ F 82 June 19,1930 Usual Residence of Decedent Marvland at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f 1 Yes 2 XNo Maryland Anne Arundel Pasadena 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7846 June Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", 3 Widowed 4 Divorced If Yes, Give Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Certified Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Self Employed Public Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Α. Hohman, Sr. Clara Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr 7846 June Drive Pasadena, Maryland 21122 <u>Jane H. Hohman (Wife)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 09/07/2012 Glen Burnie, Maryland 21. Signature of Fyneral Service Licensee MOO-732 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 1 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be completely filled in by the Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARGAY)

4304 MTN.

PASADENT NO 21122

12-06465 Brent Varney Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Certificate o	f Death	Reg	_{2. No.} 2012	2838
Pr edical E	nysici: Evami		Decedent's Name (First, Middle,Last)		2. Date of Death Month August 27,	Day Year	3. Time of Death 1338 hrs
eulcai L	_AGIIII	IIIGI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	August 27,	4c. County of Death	
			4655 Columbia Road	Ellicott City		Howard	
	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign	place (State or North
Dire	ector		239-96-0431 1\(\text{M} m 2 \(\text{F} \) 50 Yrs	Months Days Hours	June 28		Carolina
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ion			10d. Inside City Limits
Ф	how a	_	Maryland Howard Ellicott (1 Yes 2 No
arylan	8a-f s	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	
the M	s or 2		4655 Columbia Road	21041		U.S.A.	
h with	Department of frequency 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		is Decedent of Hispanic Origin' es, specify Cuban, Mexican, P		14. Race - America White, etc.	an Indian, Black,
er deat	or it		1 Yes 2 No		,	Specify: Whi	te
urs aft	tural"	Completed by	or Dates:	Yes 2 X No specify: it's Usual Occupation (Give kin	d of work done	16b. Kind of Business/In	
72 hor	n "na	etec		ost of working life. DO NOT us	e retired)		1
003 Within	Medic th	ш	4 Softw			Programmin	g
21215-0036 solld be filed within 7	t e et e	BeC	17. Father's Name (First, Middle, Last) John Edward Hill, Jr.		Name (First, Middle, Ma ara Grimes	aiden Surname)	
212	mark	о В		Address (Street and Number		er, City or Town, State, 2	Zip Code)
A 2 sho	a 27 is			Percheron Trl	.,Summerfie	eld, North Ca	arolina2735
Baltimore, MD Permit. Pages 1 and 2 sho	If iten		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or ot	ition (Name of cemetery, ner place)	Date	20c. Location - City or T	own, State
imo Page	or off		4 Donation 5 Other Specify Bethany U	CC Cemetery	9-4-12	Winston-Sa	lem,N.C.
Balt Sermit.	inpor njury			lame and Address of Facility			
Physi		H	23a. Part I. Enter the disease, groomplications that caused the death. Do not enter the	09 Harford Roa ne mode of dying, such as card	Id, Baltimor liac or respiratory arres	e,MaryLand t, shock, or heart	Approximate Interval
/Me	dical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Chest				Between Onset and Death
Exam	ııner		or condition resulting in death) Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·			
		F	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated				
19 g	d ansit		events resulting in death) Last Due to (or as a consequence of): d.				
A1.8	physician and the burial - transit	Medical	UNPENDED AMENDED				
760, icate be	physic the but		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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that th	ned by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to th	
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COTC law re	has been s 2 should	Completed			autopsy perform	prior to cor	npletion of cause of
- 7 Fe	ificate r, pag		25. Was case referred to medical	26.Place of Death (Ch	1 Yes 2	✓ No 1 Yes	2 No
Vita	this certificate has be director, page 2 sh	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Inther I		esidence 6 🗸 Other: S	Scene
of ng Ph	After this funeral dir	<u>ان</u>	27. Manner of Death 28a. Date of Injury 28b. Time of I.		Subject chat a	w injury occurred	
sion ttendi		atio	2 Accident Investigation Aug 27, 2012 1315 hrs	1 Yes 2 No			
Division of Vital Records, P.O. Attending Physician: The law requires that the safer death	I Dire	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse		or Town, Sta	eet and Number or Rura te) Road, Ellicott City, M	- 1
Division of Vital Records, P.O. Box 687 To the Hospital of Attending Physician: The law requires that the death certific within 34 hours after death	To the Funeral Director: completely filled in by the		4 Homicide 29a. Certifier (Check only 1 CertifyIng Physician: To the best of my knowledge, death occur			· · · · · · · · · · · · · · · · · · ·	
o the	o the	Medical	one) 2 • Medical Examiner:On the basis of examination and/or investigat and manner stated.				cause(s)
F 3	, F 2	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	, Day, Year)
			() (actulable)	O.C.M.E.		August 28, 2012	
3	N		Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Ba	Itimore Street. Baltimor	re. MD 21223		
		ate		The street building	.,		
3		ate	Laron Locke MD. Assistant Medical Examiner 900 W. Ba 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Itimore Street, Baltimor	re, MD 21223		

DHMH 17 Rev 1/2001 OCME 2006

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OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Anne Marie Hartley September 2012 1505 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Sprina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 213-66-2865 1 🗆 M 2 🗶 F 57 Usual Residence of Decedent 10/22/1954 Washington, DC 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Hollywood Avenue 20904 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 X Married 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Software Support 12 Information Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Loibl Elizabeth Rou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard H. Hartley/Spouse 707 Hollywood Avenue, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 09/12/2012 Brentwood. Maryland Ft. 4 ☐ Donation 5 ☐ Other (Specify) Signatore of Funeral Service Licensee Name and Address of Facility
Ines-Rinaldi Funeral Home. Inc.
1800 New Hampshire Ave., Silver Spring.
Appro M01355 23a. Part 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Advanced Cirrhosis disease or condition resulting in death) Due to (or as a consequence of) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical **Examiner**

physician

has certificate l

Division of Vital Records, P.O. Box 68760

Hospital or Attending

Physician/

Medical

Director

Funeral

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item 2

Department of I Important: If it it any injury or or once.

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Examiner

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Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical the signed by to ld be detach Completed by page 2

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 201

State

29b. Signature and title of certifier

Charu Maheshwary.

SEP 0 6 2012

31. Date filed (Month, Day, Year)

ahes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death?
25. Was case referred to medical	1		OC Please of Partly (Ch.)	24a. Was an autopsy performed 1 Yes 2 X	
25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\black \) No	Hospital:	BR/Outpatient 3 □	26. Place of Death (Che		2 T 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigati	28a. Date of injury (Month, Day, Year) on		28c. Injury at work? 1 ☐ Yes 2 ☐ No	lome 5 Residence 28d. Describe how inj	
	280 Place of Injury At h		ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
(Check 2 L Medical Exa	ysician: To the best of my know miner: On the basis of examinatio irse Practitioner: To the best of	n and/or investigation, i	in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner stated

29c. License number

1500 Forest Glen Rd., Silver Spring, MD 20910

D0068681

29d. Date signed (Month, Day, Year)

<u>September 2. 2012</u>

DHMH 17 Rev 06-2011

Registrar

		For State	Plea	Se Type or State of	of Marylan	d / Depa		of Health	n and N	-	giene	20	ble.	2839
Physicia		Registrar 1. Decedent's Name Mary		,	Hartneta			Deatr	,	2. Date of De Month			Year 012	3. Time of Death 3:00 A M
Medic Examine		4a. Facility Name (if 3108 Edg	not institution,	give street and nur			4b. City, Tow Kensi	n, or Location	n of Death	100,000	4c.	. County o	of Death	
Funeral Director		5. Social Security No. 212-54-6	575	6. Sex 1 □ M 2 X F	7. Age (In yrs. Ia	est birthday) Yrs.	If Under 1 Y		ler 24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 1	ay, Year)		Count	lace (State or Foreign ry) Ington, DC
aryland ba-f show ified at	ector	Usual Residence of 10a. State	10b. County Montgo	amo tru	10c. City	, Town or Lo				1	·, ·	701		0d. Inside City Limits
with the M s 23a or 28 ust be not	Funeral Director	10e. Street and Nun	nber	_		renszn	10f. Zip Co					tizen of Wi		try?
s after death ral", or items Examiner m	þ	11. Marital Status 1 Never Marri 3 Widowed	ied 2 🄀 Marri	12. Was Dec	2 💢 No /e			of Hispanic (Cuban, Mexic	can, Puerto	ecify Yes or No Rican, etc.)		14. Race		an Indian, etc.
ithin 72 hour lene. r than "natul the Medical	Completed	(Spe)	(Give l	dent's Usual Ookind of work do O NOT use reti	ne during m red)				ind of Bus	siness/Ind	
ld be filed w Mental Hygi larked othe atic event,	To Be	17. Father's Name (f			ly			18. Ma	ther's Nam	ne (First, Middle Lisabet	, Maiden	Surname)		
and 2 shou Health and em 27 is m ther traum		19a. Informant's Na James M. 20a. Method of Disp	Hartne	ip (Type, Print) Ltt, spou		3108		od Roc	ad, K	al Route Numbe Ensingt Date	on,		20895	5
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🗙 Burial 2 [4 □ Donation	Cremation	Removal from pecify)	State	e of H	eaven Name and A	place) Cem. Idress of Fac	9/6/	'2012 es-Rina	Sili ldi	ier S Funer	prin	g, MD Tome, Inc. g, MD 2090
be e	edical Examiner	23a. Part 1. Linter ti shock, or hear Immediate Cause (I disease or condition resulting in death) Sequentially list conif any, leading to imcause. Enter Under Cause (Disease or Ithat initiated events resulting in death)	rt failure. List or Final n nditions, imediate dying injury s	a. Meta Due to b. Due to	static (or as a conseque (or a) conseque (or a) co	Cholan ence of): ence of):			as Caldiac (от гозріга. От у а	Tool,			Approximate Interval Between Onset and Death years
ne death certific the attending ched for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 Ø 9 ☐ Unknown	months?	1 Live	tcome of pregnar Birth 2 Feta nant at time of d	Ideath 3	Ectopic preg Other (specif					23d. Date Mont		ry Day Year
quires that then signed by ould be deta	ted by PI	Part II. Other signif	icant condition	ns contributing to c	leath but not resu	ulting in the u	nderlying caus	e given in P a	art 1.					e cause of death?
Physician: The law re r this certificate has be gral director, page 2 sh		25. Was case referre								1 Tes		pr de		sy findings available npletion of cause of 2 No
ng Physiciar fter this certil uneral directo	ate: To Be	examiner? 1 Yes 2 5 27. Manner of Death	No	28a. Date	ospital: 1						y one) 5 ⚠ Residence 6 ☐ Other (Specify) Describe how injury occurred			
al or Attendi s after death Il Director: A ed in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.			M 1 ☐ Yes 2 ☐ No Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				Route Number,		
the Hospit hin 24 hour the Funera	Medical		☐ Medical Ex☐ Certifying	Physician: To the bacaminer: On the ba	sis of examination	and/or invest	death occurred	pinion, death I at the time,	occurred a date and pl	t the time, date	and place the cause	, and due te e(s) and ma	to the cau inner as st	se(s) and manner state ated.
o o o		29b. Signature and t	Mol	wor	7			H0064				te signed (
) V	2	30. Name and address Joanna M 31. Date filed (Month)	ess of person w . Delar h, Day Year)	ney, M.D.	, 10400	Conne	cticut	Aue.,	#606	Kensi	ngto	n, MI	20	1895
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		artment of F <i>tificate of D</i>			iene 20	12	28391
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last	ose Marie H				2. Date of Death	n Dav Y	'ear	3. Time of Death
- 1000	Medic Examin	cal	4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Death	Augus		12	4:40 рм
-			1701 Glastonbe				Potomac		Mona	tgome	
	Funeral Director		5. Social Security Number 6. Set 095-20-1294	7. Age (In)	yrs. last birthday) % Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Country)	
	nd Tow	Ļ	Usual Residence of Decedent 10a. State 10b. County		85 Yrs. c. City, Town or Loc	cation		June 24	,1927		Iew York Inside City Limits
	Marylar 8a-f sl tified	Director	Maryland Montgo		or only, fower or Loc	Sation	Potomo	ıc		100.	1 🗆 Yes 2 🛣 No
	th the I		10e. Street and Number	2 1		10f. Zip Code	22674	1	0g. Citizen of Wh		
	eath wi	Funeral	1701 Glastonbe	12. Was Decedent Ever in		Vas Decedent of Hi	20854 spanic Origin? (Sp	ecify Yes or No-	14. Race -	U.S.	
920	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates.	li li	f Yes, specify Cuba ☐ Yes 2 1 No	n, Mexican, Puerto	Rican, etc.)		White, etc.	
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pu	e filed y	To Be	17. Father's Name (First, Middle, Last)	Tales Vasses to			18. Mother's Nam	e (First, Middle, M	,		
aryle	should be finand Menta ris marked raumatic ev		19a. Informant's Name/Relationship (Тур	John Kapusto e.Print)		g Address (Street a	and Number or Bur	Adela D		e Zin Code	al
Ž,	2 ± 2 ± 2		Susan Hickok - 1			Sagamore					
Baltimore, Maryland 21215-0036	Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ I	Removal from State		natory or other place	e)		20c. Location - Ci		
altin	せっせる		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	11.4	emory's (01864 22						New York ome, Inc.
Ö	permi Depar Impo any ir		· Katrina +	. Smith	11.	800 New H	lampshire	Ave., Si	lver Spr		
-22 J	Physician/ Medical		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line. Pelvic Ne Due to (or as a con	2oplasm	r the mode of dying	g, such as cardiac	or respiratory arres	t,	Int	pproximate terval Between aset and Death I Year
	Examiner	er	Sequentially list conditions,	Due to (or as a con	anguages of					_	
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_	cate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a con-	sequence of):		-				
3760	ficate to g physical as the l	Nedical		l			-	_			
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	3c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date o	,	y Year
P.0	that the	by Pr	Part II. Other significant conditions cor	tributing to death but no	t resulting in the un	nderlying cause give	en in Part I.	23e. Did toba	acco use contribu	te to the ca	ause of death?
rds,	equires neen sig hould t							1 🗆 Yes	2X No 3	Probabl	y 4 🗌 Unknown
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of Vi	r this ceral din	<u>م</u>	1 ☐ Yes 2 🂢 No	28a. Date of injury	2 ER/Outpatient	28c. Injury	4 L Nursing Ho	me 5X Residen 28d. Describe how		Specify)	
ouo	ending eath. or: Afte the fun	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year	r) injury	work?		20d. Describe now	injury occurred		
Division of Vital Records, P.O.	al or Att s after d il Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, stre ec <i>ify)</i>	et, factory, office		28f. Location (Stre City or Town,		r Rural Rou	rte Number,
	ne Hospit n 24 hour ne Funera	Medical	(Check 2 \(\subseteq \text{ Medical Examine}	cian: To the best of my kreer: On the basis of examin Practitioner: To the best	ation and/or investi	gation, in my opinior	 death occurred at 	the time, date and	place, and due to	the cause(s	s) and manner stated.
	Vithi Voth		29b. Signature and title of certifier	1 .1		29c. License	number		d. Date signed (M	onth, Day,	Year)
	6.1		30. Name and address of person who co	Mulliman moleted cause of death (D0027985		August	30,	2012
	150		William Silverman,	M.D., 1201	I Seven L	ocks Roa	d, Suite	111, Roc	kville,	Mary	land 20854
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 6 2012	32. Registrar's Si	gnature						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 201 28392 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year •ZD 4.45AM Raymond Monroe Hood, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 220-16-8540 1**XX**M 2 □ F 84 10/12/1927 MD Usual Residence of Decedent in then "neturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours efter death with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 North Jerome Parkway 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1. No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2XX Married δ Saltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) AA Co. Public Works Supervisor Be permit. Page 1 and 2 should be filed Depertment of Health and Mental Hy Importent: If Item 27 is merked oth eny Injury or other treumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferris Hood Anna Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Vera Hood / Wife 24 North Jerome Parkway Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial ✓P ☐ Cremation 3 ☐ Removal from State on 5 (1) Other (Specify) 9/7/2012 Glen Haven Memorial Glen Burnie, MD 21061 21. Signatur of Furter Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23 . Part 1. Enter the diseas , complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ettending physiclen and for use es the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Hospitel or Attending Physicien: The lew requires thet the deeth certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown g 🔲 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate hes been signated page 2 should be Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Anpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral 28a. Date of injury (Month, Day, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hour. the Funerel Directory filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause C On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying N within 2 only one rse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a d title of certifie 29d. Date signed (Mohth, Day, Year) QXIV 30. Name and address who completed cause of death (Item 23a) (Type, Print) Burn Date filed (Month, Day, Year) 32. Begistrar's Signature Registrar DHMH 17 Rev 06-2011

				AMEND #17 PER F	Type or P H, PI LIN State of I	rint in J Marylan	Black In 25 PER d / Depa	delible Ink ME G931 rtment of H	Ensure 9/5/12 lealth and l	All Copie IRT Mental Hy	s Are L	egible.	00000
				State Registrar			Cert	ificate of D	Death		Reg. No.2	012	28393
		Physicia	an/	1. Decedent's Name (First, Middle, La	ast)					2. Date of De	eath Day	Year	3. Time of Death
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- (Examir	ner	4a. Facility Name (if not institution, given		•		4b. City, Town, or	Location of Death	~		ounty of Death	
•		Furnaval		UPPER CHESAPEAKE 5. Social Security Number 6.		CENTE Age (In yrs. Ia		BEL If Under 1 Year	AIR If Under 24 Hrs.	I 8. Date of Bir		RFORD G Right	place (State or Foreign
	М	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	1 X M 2 □ F	-tgc (111)/13. //		Months Days	Hours Min.	(Month, Da	ay, Year)	Cour	ntry)
		W	١.	Usual Residence of Decedent		Ý	//			02/14	/1973		TUCKY
		Maryland 28a-f show otified at	턍	10a. State 10b. County		10c. Cit	y, Town or Loca	ation					10d. Inside City Limits 1 ☐ Yes 2 🛣No
		e Mau r 28a notifi	Director	MARYLAND HARFO	RD CO		AB	ERDEEN 10f. Zip Code			10 011	514/1-1-0	
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is		72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral	41 ROOSEVELT	12. Was Deceder	t Ever in U.S	6. 13. W	210 as Decedent of His	OI spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		S.A. Race - Americ	can Indian.
1815	9	or it	by F	1 Never Married 2 🛚 Married						Rican, etc.)		Black, White,	etc.
	21215-0036	2 hours after death v "natural", or items edical Examiner mu	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1	☐ Yes 2 🛛 No	Specify:		Spe	ocify: KOKE	AN/AMERICAN
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10	12	within 73 giene. ier than the Me	9	Elementary/Secondary (0-12)	College (1-4 c	r 5+)		NOT use retired)			COCM	ETICS	
1		led withir Hygiene other tha ent, the I	Be	12yrs 17. Father's Name (First, Middle, Last,)		ISUPE	RVISOR	18. Mother's Nan	ne (First, Middle			
	lan	nould be filed with and Mental Hygier s marked other tumatic event, th	၉	TERRY A. JONA	S JONCAS				MASAKO	SON			
	Maryland	should and N is ma aumai		19a. Informant's Name/Relationship	Type, Print)		19b. Mailing	Address (Street a	and Number or Rui	al Route Numbe	er, City or Tov	vn, State, Zip	Code)
3		nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event; the Medical Examiner must be notified at		Masako Joncas/Mo	ther		41 Ro	osevelt_	Ave. Apt	D1. Ab	erdeen	Md	21001
201	ore	e 1 ag cof H if itel		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Sta		Place of Disposi emetery, crema	tion (Name of atory or other place	e)	Date	20c. Locat	tion - City or To	own, State
	E.	: Pag tment tant: jury c		4 Donation 5 Other (Spec	cify)		ro cre			04-12			MARYLAND
29,	Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of al/S	excur	2	WI	Name and Addres LLIAM C	BROWN CO	MM FUNE	RAL HO	ME-HAR	FORD, P.A.
		202 00		23a. Part 1. Enter the disease, or cor				ZI S FRI	LADEFULA	$DUVU_{\bullet}A$	DEKDEE	N, MD	21001 Approximate
10.0. August		Medical Examiner uand tual-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Il any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events	a. Due to (or a Due to (or a C.	SIVE as a consequ RTENS	uence of): EON uence of):	Ra CERS	eloral F	1	e1/	1	Interval Between Onset and Death
P	09,		1= 1	resulting in death) Last	Due to (or a	as a consequ	uence of);		CHININE	VED BY MEDICAL F	ORTAL HOLLAS	Harrage	
6	ision of Vital Records, P.O. Box 68760 Atending Physician: The law requires that the death certificate be accordent the time certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the but			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	h 2 ☐ Feta tat time of d	al death 3	Ectopic pregnancy Other (specify)	у		230	d. Date of deliv Month	very Day Year
Erne		requires that to been signed be should be deta	ed by P	Part II. Other significant conditions Diabetes	contributing to death	n but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did 1			the cause of death?
mother	of Vital Records,	The law recate has be page 2 sh	Completed by Physician/Medical	•								24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
2	ital	Physician: The this certificate ral director, pag	Be l	25. Was case referred to medical examiner?	Hospital:			Louis .	ace of Death (Chec				
1=	f V	Phys this ral di	12	1 X Yes 2 1 No	1 Inp 28a. Date of in		ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4 ☐ Nursing H	ome 5 Resi			y)
,		ding F th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, l	Day, Year)	injury	work'		20d. Describe	now injury oc	Curred	
ondas	Division	l or Attendi after death. Director: A I in by the fu	Certificate:	3 Suicide 6 Could not	be 28e. Place of I			t, factory, office				umber or Rura	al Route Number,
20	Div	afte Dir I in			building,	etc. (Specify	"			City or To	wn, State)		
3		Hos 14 h Fun tely	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best niner: On the basis o rse Practitioner: To	f examination	n and/or investig	ation, in my opinio	n, death occurred a	at the time, date	and place, an	d due to the ca	ause(s) and manner stated.
1.		To the within 2		29b. Signature and title of certifier	200		47	29c. License				igned (Month,	Day, Year)
16		MM		31	1	7	1 44		5356		Augus		1,2012
2		Dh. 1		30. Name and address of person who	_	T 7	i 23a) (Type, Pri	nt) 500	Upper		-	alee &	Dave
1	78'	Sta	te	31. Date filed (Month, Day, Year)	Non DSON	strar's Signa	ture	150	ACE		wigh	a57d	-1014
K		Registr		SEP 0 6 2012	See 1		all						
10	DH	MH 17 Rev 06-	2011	/	2010ting	17							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28394 State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ AUBUST Hazel Irene Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fahrney-Keedy Memorial Home Boonsboro Washington 8. Date of Birth
Dec 3, 1911 Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 220-18-0391 Maryland 100 1 □ M 2**X** F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Blue Ridge Dr. 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) nurses aide healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Thompson Obitts Emma Kate Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Sunrise Circle; Boonsboro, MD 21713 Carolyn Bowman - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signatur Funeral Service Licens Bonal d S 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Deter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Dementio disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Hospital or Attending Physician: The law requires that the $\mathcal{H}AZEL$ Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MacUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No Yes 24 hours after deau..

e Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Aatural 5 Pending Accident Investigation 1 Yes 2 No ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 2323 08-29-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad Kalid Waseem 1126 Opal Court

DHMH 17 Rev 06-2011

State Registrar Hagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:20 PM Medical Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under g. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Min. Hours 08/08/1961 216-74-3840 Mary land Director 1 🗆 M 2 😾 F 51 Yrs ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MO n/a 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 USA 203 South Dallas Court Page 1 and 2 should be filed within 72 hours after death w ment of Health and Mental Hygiene. ant: If item 27 is marked other than "naturai", or items : Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give X Black White etc. δ 1 Never Married 2 Married 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled n/a Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gladys E. Hicks Frederick Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zin Code) 261 South Ballou Court Baltimore, MD 21231 Ebony Kidd / Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 09.07.2012 Baltimore, MD Donation 5 Other (Specify) 22 Name and Address of Facility
John L. Williams Funeral Directors, P.A. 4517 Park Heights Avenue Baltimore, MD 21215 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme wite Cause (Final Physician/ Cardiac arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner syndrome QT Long Sequentially list conditions if any, leading to immediate cause Ther Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death been signed by the a should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy After this certificate rs after deam.
rai Director: After this cerum.
rin by the funeral director, pr 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Orleans Street Rod Rahimi

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2012

_	1 - For State Registrar	State of Mar		irtment of F <i>tificate of</i>	lealth and I				
	Registrar 1. Decedent's Name (First, Middle, Last		Cei	lilicate of	Dealli	2. Date of De	Reg. No.	1 / 2 2 72 8 2 3	
an	OCTAVIA)	JUNG	- e		Month	Day	Year S. The blogain	
al	4a. Facility Name (If not institution, give		7 0 0		or Location of Death	AUGUS	4c. County of	012 8:301	
er	FUTULE CARE	OLD CUUR		RANDA	FLCS TO W	(A)	BAL	TIMORE	
	5. Social Security Number 6. Se 212–26–9729 1 Usual Residence of Decedent		(In yrs. last birthday) 84 Yrs.	Months Days	Hours Min.		ⁿ y, Year) -1927	Birthplace (State or Forei Country) MARYLAND	
tor	10a. State 10b. County MD N/A	1	0c. City, Town or Lo					10d. Inside City Limi 1 XYes 2 □ N	
Funeral Director	10e. Street and Number 4716 WRENWOOD AV	Ε.		10f. Zip Gode 21212	10g. Citizen of What Country? USA				
ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of h	Hispanic Origin? (S	pecify Yes or No		- American Indian, , White, etc.	
by	1 □ Never Married 2 □ Married 3 □ Widowed 4 🛂 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		I □ Yes X No		BLACK			
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Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retire EACHER			ALTIMORE CITY		
To Be	17. Father's Name (First, Middle, Last) LEO WILLIAMS 18. Mother's Name (First, Middle, Maiden Surname) MARY HICKS								
Ċ	19a. Informant's Name/Relationship (T)			-	and Number or Ru			State, Zip Code)	
	LATON JONES (GRAN	DDAUGHTER)			MEDA BALT				
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I	Removal from State		natory or other pla		Date		City or Town, State	
	4 Donation 5 Dother (Specify,	TONATUAN	ARBUTUS N					RE, MARYLAND	
	21. Signature of Funeral Service Libens	0 9k	P. HIBIND	Name and Addre 1721–27	ess of Facility PH N. MONROE	ST. BAI	TIMORE,	HOME, P.A. MARŶLAND 212	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			ForState	State of Ma	aryland /				Mental Hy	giene		00007
			Registrar Certificate of Death Reg. No. 2									28397
	Physicia		1. Decedent's Name (First, Middle, L.	Earl C. Kautz, Jr.							Year 12	3. Time of Death
Side.	Medio Examin		4a. Facility Name (if not institution, gi				City, Town, or	Location of Death	0	9 01 4c. County		2230 1
أمري			Prince George's	s Hospital	Center		Cheve	erly, MD		Pri	nce G	eorges
	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. last bii	rthday) If U	nder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birl	h		olace (State or Foreign
	Director		204-28-9103 Usual Residence of Decedent	1 🛣 M 2 🗆 F	73	Yrs.				/1939		PA
	n 72 hours after death with the Maryland a. "natural", or items 23a or 28a-f show Medical Examiner must be notified at	jo	10a. State 10b. County		10c. City, Tow	vn or Location					1	0d. Inside City Limits
		Director	MD Charle	es	Wa1	dorf						1 ☐ Yes 2 ☐ No
	h the		10e. Street and Number			10f	Zip Code			10g. Citizen of	What Cour	ntry?
	th with ms 23 must must	Funeral	70 Village Stre			140.04		20601	- 12 M		SA	
	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🏋		13. Was De	specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ce - Americ ck, White,	
21215-0036	s afte ral", (Exan	ed b	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	140	1 □ Y€	s 2 🛚 No	Specify:		Specify	Wh	ite
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Maryland	should be file and Mental H is marked o raumatic eve	욘	Earl C. Kautz, Sr. Janet Leona Oster									
ary	1 and 2 should be of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship	State, Zip (Code)							
Σ.	and 2 s Health s tem 27	П	Susan Kauffman	/ daughter				ve, Wald	orf, MD	20601		
Baltimore,	je 1a it of H : If ite or oth		20a. Method of Disposition 1	☐ Removal from State	cemete	of Disposition ery, crematory	or other plac		Date	20c. Location		
Iţim	it. Pag rtmen rtant: njury	1	4 Donation 5 Other (Special	-	Mounty	ville B		, 770	/2012	Mount		
Ba	permit. Page 1 a Department of H Important: If ite any injury or ot once.	7	21. \$ ignature Funeral Service/Lin	2100	27		e and Addres	32	8 W. Or	ange St & Crema	. Lan	caster, PA Srvcs, Inc.
			23a. Part 1. Enter the disease, or co						_ ·			Approximate
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0	cate be executed physician and s the burial-transit	edical		d								
8760	ificate ig phy as the		IF FEMALE:									
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Bo	requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Othe	r (specify)			Me	onth	Day Year
P.O.	at the		Part II. Other significant conditions	contributing to death b	ut not resulting	in the underly	ng cause giv	ren in Part I.	23e. Did to	bacco use con	ribute to th	ne cause of death?
S, F	uires t	ed by							1 🗆	Yes 2 □ No	3 🗆 Prob	pably 4 Unknown
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0 U	ding I th. After fune	cate	1 Natural 5 Pending 2 Accident Investigati	(Month, Day	; Year)	injury M	28c. Injury work	7 at ? Yes 2 □ No	28d. Describe h	ow injury occur	ea	
isio	Atten er deal ector: by the	Certificate:	3 Suicide 6 Could not	be 28e. Place of Inju						treet and Numb	er or Rural	Route Number,
Division of Vital Records,	tal or rs afte al Dire		,	building, etc	. (Specify)				City or Tow	n, State)		
	Hospi 4 hou Funer tely fill	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Example)	ysician: To the best of miner: On the basis of ex	my knowledge, kamination and/	, death occurre	d at the time	e, date and place, a on, death occurred a	and due to the ca	ause(s) and man	ner as stat	ed. use(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ž		rse Practitioner: To the				he time, date and pl			manner as	stated.
	F 3 F 8			- Mn			000	6842	9	9 4	4 1	2
	101/		30. Name and address of person who	completed cause of de	eath (Item_23a)	(Type, Print)√	VVV ,	1 1	11	, !		
	1 9		Ziba	Shiran	i 300	1 HO	Spita	9/ DK	Chev.	IRly	mi	0 20185
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 6 2012	32. Registr	r's Signature	المعا						

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 28398 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 Mary Vaughn Luhman 1:30pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gaithersburg 2 Cinzano Court Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days **Director** 329-36-7749 1 □ M 2 🗴 F May 17, 69 1943 Missouri 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Gaithersburg Maruland 1 Yes 2 X No Montgomery o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2 Cinzano Court 20878 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black. White, etc. than "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Completed 3 Widowed 4 X Divorced Caucasian Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Manager is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ပ Paul V. Vaughn Sophia Heider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 166 W. Slatestone Circle, The Woodlands, Texas 77382 Cynthia Cardone - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ment of 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 09/04/2012 Brentwood, Maryland Lincoln Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death

10 Months Immediate Cause (Final Providicaci Small Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner quantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year Pregnant at time of death a Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗶 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at w<u>ork</u>? Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident s after death. 1 Yes 2 🗌 No Investigation the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0063828 August 30, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9715 Medical Center Drive, Rockville, Maryland 20850 DongMei Wang,

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland /					Mental Hy	giene 21	012	28399		
			Registrar 1. Decedent's Name (First, Middle	e, Last)		Certii	ficate c	t Dea	ath	2. Date of De	Reg. No.	J 1 L.	100		
	Physici Medi			Willie N	Lacy					Month	Day ug 29, 201	Year 2			
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	Funeral Director		247-76-4475	1 X M 2 □ F	66		fonths Da		ours Min.	(Month, Da			trv)		
	land show d at	٥	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Locati	ion					1	0d. Inside City Limits		
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	death with the Maryland items 23a or 28a-f sho ier must be notified at	ralD	10e. Street and Number 1100 Bolton Street				10f. Zip Cod		21201		10g. Citizen of	What Cour			
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2	ryla	2	10 h () () ()	Johnnie M. L					_		nevieve l				
	2 5 ± 5 ±		19a. Informant's Name/Relations Marguerite Lacy	nip (<i>type, Print)</i>	19	_	Address <i>(Str</i> B olton S			al Route Numbe nore, MD 2	er, City or Town, 21201	State, Zip (Code)		
Š	e 1 and Control of Height		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 ☐ Removal from State		of Disposition	on (Name of ory or other	place)		Date	20c. Location	- City or To	own, State		
o de la comitación de l	Pag ment		4 Donation 5 Other (21. Signature) of Funeral Service	Specify)		Mt. Zion		_		07, 2012	Lans	downe	, Maryland		
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<u>₩</u>	that the ned by t	y Ph	Part II. Other significant condition	contributing to death b	out not resulting	g in the unde	erlying caus	e given in	Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?		
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3	the Hos hin 24 հ the Fun tpletely	Medical	(Check 2 🔲 Medical I		xamination and	or investigat	tion, in my o	oinion, de	eath occurred a	t the time, date a	and place, and du	ue to the cau	use(s) and manner stated.		
	То t Vith		29b. Signature and title of certifie	Palm	1/1	M	29c. Lic	ense num	13 (1)		29d. Date signe	d (Month,	bay, Year)		
4			30. Name and address of person	who completed gause of a	eath (Item 23a)	(Type, Print	Moto	1/6	5 5	1.13	THO	1/12	12/9		
H	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 0.6	2012 32 Registra	ar's Signature	par	L.					, •,	,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland /				Mental Hy	giene			
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	<i>Death</i>	2. Date of Death 2 2 3 1700 of Death				
	Physicia Medi		James Henry Lynch				st 29, 2012 2030 M				
of the	Examin	ner	4a. Facility Name (if not institution, give street and number) FutureCare Homewood	4c. County of Death							
4-7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs			g. Birthp	place (State or Foreign	
	Director		246–62–2837 Usual Residence of Decedent 1X M 2 □ F 72	Yrs.	Months Days	Hours Min.	01/15/	1940	NC Coun	try)	
	fand show dat	tor	10a. State 10b. County 10c. City, To MD n/a	wn or Loc	ation Itimore				1	0d. Inside City Limits	
	r 28a-i r otifie	Director	10e. Street and Number							1 XYes 2 No	
	s 23a o	Funeral	2406 East Eager Street		10f. Zip Code 2120	15		10g. Citizen of V	What Coun	try?	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerl	oecify Yes or No- o Rican, etc.)	Blac	e - Americ k, White, e Blac	etc.	
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Baltimore,	ermit. Page 1.8 er artment of Perartment of Perartment. If its my injury or ot once.		1 Burial 2 Cremation 3 Removal from State Cremation 4 Donation 5 Other (Specify)	of Dispos ery, crem	sition (Name of atory or other place enter of M	09.10	.2012	20c. Location - Hanover,		wn, State	
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ita	I or Attending Physician: The after death. Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FB/C		Other	ce of Death (Chec	ck only one)				
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_	e Hospital 24 hours a E Funeral D letely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and/only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 2 Medical Examiner: To the best of my knowledge 3 Certifying Nurse Practitioner: To the best of my knowledge 4 Certifying Nurse Practitioner: To the best of my knowledge 5 Certifying Nurse Practitioner: To the best of my knowledge 5 Certifying Physician: To the best of my knowledge 6 Certifying Physician: To the best of my knowledge 7 Certifying Physician: To the best of my knowledge 7 Certifying Physician: To the best of my knowledge 7 Certifying Physician: To the best of my knowledge 7 Certifying Physician: To the best of my knowledge 8 Certifying Physician: To the best of my knowledge 9 Certifying Physician: To the best of my know	or investig	gation, in my opinion	, death occurred a	at the time, date an	d place, and due	to the caus	se(s) and manner stated.	
	To the within 2 To the comple	2	29b. Signature and title of certifier	mougo, c	29c. License r	-		9d. Date signed			
			Paymond Milli Mo			.7683		9/5/12			
			30. Name and addless of person who completed cause of death (Item 23a) Ruy mond Millio Po Box (525		ringi Mi	11. MD	21117				
	Stat	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	See de							
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DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Means Jr. Robert Medical Sept 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 29 Warren Park Drive Apt. 2982 Pikesville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Director 215-04-1503 1 X M 2 🗆 F 55 11-20-1956 SC 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 27 is marked other than "natural", or items 23e or 28e-f sl treumatic event, the Modical Examiner must be notified a BALTIMORE Pikesville 1 Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Funeral 29 Warren Park Drive Apt. 2982 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African-American If Yes, Give Year or Dates 3 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 Pand Mental Hyglene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Veterans Administration 12th Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Robert Means Sr. Janie Scott , Page 1 end 2 should b ment of Health and Mei tent: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Cross/wife 29 Warren Park drive, Apt. 2982, Pikesville, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory permit, Page 1 e Department of H Importent: If ite any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 9-6-2012 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 9200 Liberty Road Randallstown, Maryland 21244 23a. Part 1. Enter the disease, or complications, or heart failure. List only one fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Examiner ine pulmonory disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician end I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death signed by the at id be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Ves 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 21b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate Yes 2 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to Certificate: To Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗀 Homicide City or Town, State Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) 2012 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -TIMORE 21201 N-EUTAW STREET 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 931 9-14-12 yt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Miller 3:05 PM Clarence 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death uture Care cherrywood Baltimore Reisterstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 10/03/1927 **Director** 216-24-6087 84 1 🛛 M 2 🗆 F Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 427 Silver Run Valley Road 21158 U.S.A. Page 1 and 2 should be filed within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ³₩Widowed 4 □ Divorced Completed Specify: White Year or Dates other than "naturent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Ice Cream Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked (Clarence F. Miller, Sr. Elsie Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is |Sandra White (Daughter) 427 Silver Run Valley Road, Westminster, Md. 21158 Department of Health Important: If item 27 any injury or other trong once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Holly Hill Mem. Gard. 09/05/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Atture VI Ustal See it e Licensee 22. Name and Address of Facility Bruzdziński Funeral Home, 1407 Old Eastern Avenue, Essex, P.A. Maryland 21221 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final chronic obstructive pulmonary disease Physician/ disce or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Due to for as a nonsequence of, the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? be detached for Month Day Year 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 1 Tes 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: - 1 ☐ Yes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle of certifier September 3, 2012 MD D 7033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 2013 Solisbury, MD 21802 21. Date filed (Month, D Lijun Zhon

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Plack Indelible Ink. Ensure All Copies Are Legible. State of Marylar / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 25 A.M Sept. 2012 Margaret M. Marshall Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MD Masonic Home Baltimore Cockeysville Social Security Number 8. Date of Birth (Month, Day, Year) June 6 1920 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Days Min Hours Country) **Director** 220-50-1921 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🛣 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 300 International Circle 21030 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: white Completed 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Henry Naynes Elsie O. Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon George/daughter 216 Mysticwood Rd., Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Mary's Cemetery 9/6/12 Balto., MD 21. Signature of Furnaral Service Locensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Mickael Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stone Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence oi). it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s after death.

Director: After this certificate! 1 Yes 2 No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Sursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 ROBERT

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28404 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Josefina Uday ^{Day}, 2012 Mehta September 6:45A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12 Silverwood Court Nottingham Baltimore If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. . Social Security Numbe 218-76-3557 Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 1 □ M 2 🂢 F 61 April 18,1951 Philippines permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Silverwood Court 21236 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Completed by Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rafael DeLaCruz Dominga DeLaCruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uday Mehta: Husband 12 Silverwood Court, Nottingham, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Crempter), compatory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 9-2-12 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland Center of Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael P. mar 6009 Harford Road, Baltimore, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical law requires that the death certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🔲 Ectopic pregnancy 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical was case recommended and the examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Ø State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:159 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Necitas Group Home Silver Spring Montgomery Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕇 F Days 9/98/1968 577-60-2033 washington. DC **Director** 105 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🔏 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 13320 Bea Kay Drive 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: African-American Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Randolph Ida Mae Bolton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13320 Bea Kay Drive, Silver Spring, MD 20904 Odessa M. Shannon, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 9/8/2012 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 21. Signature of Fund al Service Lice 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Me disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director, Be 2 🗖 No Hospital: Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Group Home ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pt 24 hours after death. e Funeral Director: After th 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident

Suicide

Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 26434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHMENER 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical September D Genrietta Mazina 9:20 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 222-76-2388 1 □ M 2 🗓 F 82 11/15/1929 Ukraine Usual Residence of Deceder permit, Page 1 and 2 should be filed within 72 hours aner uparting the permit of Heelth and Mental Hygiene.

Important: If them 27 is marked other than "natural", or items 23a or 28a-f show in the mast is marked other than "natural", or items 25a or 28a-f show in the mast traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10250 Westlake Drive. #509 20817 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian was Decedent Ever Armed Forces?, 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Organic Chemist Research Institute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elena Mazin Eiderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vlad Mazin, 10414 Snow Point Drive, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Society) Gdn. of Remembrance 9/4/2012 Clarksburg, MD 21. Sign iture of Funerur Serv 22. Name and Address of Facility Hines-Rinalli Funeral Home. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure) List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): 24 hours after death, by certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant. 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) ð 27. Manner Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 6 2012

10121/10, GENITIE HO

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SCONSIN AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 August Marjorie Hodges Mills 4:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 407 Russell Avenue, Gaithersburg Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Months Hours Director 564-26-7256 1 □ M 2 💢 F 87 July 22, 1925 New York Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits əms 23a or 28a-f sh r must be notified a Gaithersburg Maryland 1 Tes 2 X No Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 407 Russell Avenue. #214 20877 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian o, ò Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed "natural" 3 X Widowed 4 □ Divorced Specify: Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than vent, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Quilter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F item 27 is marked of ပ Charles Hodges Marjorie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Chamounix Road, St. Davids, PA 19087 Christopher Mills - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 0 cemetery, crematory or other place 1 Durial 2 X Cremation 3 D Removal from State Department of Important: If any injury or once. Ft. 4 Donation 5 Other (Specify) Lincoln Crematory 09/04/2012 Brentwood, Maryland Funeral Service 21. Signature of 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center Licensee MIOZOG 1040 Rockville Pike, Rockville, Maryland 20852 23a, Part 1. Enter the Part 1. Enter the lise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillium. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Ovarian Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Disk to for as a pur sequence of, anding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Month Year Day 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗶 No ည 1 Inpatient 2 I 4 Nursing Home 5 X Residence 6 Other (Specify) ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifie

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Geoffrey Coleman, M.D.,

31. Date filed (Month, Day, Year)

SEP 0 6 2012

D37142

1355 Piccard Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

August 28, 2012

0 Sesteman

State of Maryland / Department of Health and Mental Hygiene 28408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September De 2 0 T 2 Carol Ann McGarril 1500 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min 523-80-4556 Director 1 🗆 M 2 💢 F 8, 1955 Washington show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 433 Christopher Avenue, #31 20879 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in 0.5.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 73-77 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) Secretary Office Law other traumatic event, Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne, should be file and Mental F is marked of ၉ Ketels Joan Shirley Evan Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Kathy Widing, 2806 Serramonte, Denair, CA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If is any injury or or 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Lincoln Crematory 9/11/2012 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral/Cremation 21. Signature of Funeral Service License Center, 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ HodaKins disease or condition resulting in death) months Von Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and defached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) _ in the past 12 months?
1 ☐ Yes 2 ☑ No Month 1 Yes 2 Unknown Part II. **Other** s**ignificant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available certificate has autopsy performed? 1 Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🖎 No Other: 욛 1 🗌 Yes hours after death.

neral Director: After this or

y filled in by the funeral dire 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33224 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trehan 1400 Forest Clen Rd #1400 Silver Spring, 31. Date filed (Month, Day, Year) State SEP 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH#31perDVR, G931, 9/6/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:50 AM August William Dennis Montgomery Medical 4a. Facility Name (if not institution, give street and number) Examiner Balling City, Town, or Location of Death 4c. County of Death Baltimae HOSPITAL OF N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Director 213-34-7026 1 🕻 M 2 🗆 F 75 SC Yrs Apr 28, 1937 dence of Decede 10a. State 10b. County within 72 hours after deeth with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2323 Sidney Avenue 21230 U.S.A. ed other then "neturel", or Items event, the Medical Examiner ma 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) **Glass Maker** Maryland Glass 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Montgomery Mary Lou James 19a. Informant's Name/Relationship (Type, Print)
Gwendolyn Denise Montgomery
Denise Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Sidney Avenue, Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sep 08, 2012 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature 1914 neral Service License mpoi any ir 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, of complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician/ Medical Due to (or as a consequence of) Examiner T.S.Chemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit NTY a CI that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No |요 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific -000 2401 W betvedere AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADISP SINAZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State P 0 6 201 Registrar DHMH 17 Rev 06-2011

MONTGOMERY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 201 2 Physician/ Edwin Gerald McCall 3:35 pm eptember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St-Agnes

5. Social Security Number Hospital Baitimore If Under 1 Year | If Under 24 Hrs. | Hours | Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 217-30-2698 Director 1**XX**M 2 □ F 78 8 / 24 / WV 34 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes XX No Baltimore Halethrope 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2912 Georgia Avenue 21227 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2XX Married 1 ☐ Yes 2XXNo If Yes, Give 3altimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steamfitter Construction Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norman McCall Katherine Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marie McCall Wife 2912 Georgia Avenue Halethrope, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State 4 Dona on 5 Other (Specify) Cedar Hill Cemetery 9/8/2012 Brooklyn, MD 21. Signature of Fundial Service Licensee 22. Name and Address of FacilitySingleton Funeral & Cremation 10:220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Coronary Medical Due to (or as a consequence of): Examiner Valve urtic Y COFS Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Inten me September 4, 2012 5 46505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OA Twanmoh, MD 900 Caton Ave Baltimore, Maryland 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OP Physician/ Month 1av 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** Elizabeth Nursing Bal timore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb 8, 1931 1 🗆 M 2 🗓 F Maryland 81 Director 213-28-2790 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21227 3300 Benson Avenue items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, et þ "natural", or 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify. 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home unk unk Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Molie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2628 Lehman St; Baltimore, MD 21223 19a. Informant's Name/Relationship (Type, Print) Sharon McMannus - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Boston University of Medicine ö Sch 8/30/2012 Boston, Massachusetts any injury 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Sign of Funeral Ser Director 655 W. Baltimore St; Baltimore, MD 212J1 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dis-ease monar Pnysician/ 0 nvom c disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list condulons, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Physician/Medical 15m P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death ed by the a q Unknown g Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disorder Records, 2 No 3 Probably 4 Unknown 1 Yes page 2 should rebral vaecular accident-24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Wyperlinidemia 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case eferred to edical Be Division of Vital 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 0 6

Mn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

enson

3320

29d. Date signed (Month, Day, Year)

an

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland /		ment of He ficate of D			ene 2012	28412	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	MACK				2. Date of Death	30 201	3. Time of Death 12 9: 53 AM	
	/Medic Examin Funeral	er	5. Social Security Number 6. Sex	reet and number) PSP1777 7. Age (In yrs. last. TU	birthday)	b. City, Town, or Balti f Under 1 Year Honths Days	If Under 24 Hrs.	8. Date of Birth 0 9 1 9 7 1	Ac County of Dea	th The state of Foreign outry Carolina	
	Director		Usual Residence of Decedent	1 11	Yrs.			09/19/1	937 N.	10d. Inside City Limits	
	Marylan f show	tor	MD N/A	10c. City, 10	own or Local		ltimore			1 📆 Yes 2 🗌 No	
	with the	i Direc	10e. Street and Number 1510 W. Mosher	St. Apt 4H		10f. Zip Code 212	17	10	og. Citizen of What C		
36	be filed within 72 hours after death with the Maryland ital Hygiene. dig other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		s Decedent of Hises, specify Cubar	spanic Origin? (Spanic Argumento Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:		
21215-0036	in 72 hou n "natura fedical E	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give kir life. DO	NOT use retired)	uring most of work	ing	16b. Kind of Business		
	filed within Hygiene. other then *	Com	Figure 12 Caracter (0-12)	College (1-4or 5+)	Ca	shier	18. Mother's Name			teakhouse	
land	iould be fill I Mentat H harked ott hatic even	To Be	17. Father's Name (First, Middle, Last) Horace Bowden S	r.				e Lewis			
Maryland	and and is m		19a. Informant's Name/Relationship (Type Kenya Pevie (Gr						City or Town, State,		
Baltimore, I	@ ° = 5		20a. Method of Disposition 1 **The Burial 2 Cremation 3 Received the Company of	20b. Place ceme	e of Disposit etery, crema	ion (Name of tory or other place	9)	Date	20c. Location - City o	r Town, State	
Balti	permit. Pag Department Important: any injury c		21. Signature of Funeral Service License		237 8	SEBIAdd PA	s Brown	Jr. FUr Ave., I	neral Hom Baltimore	me PA e,MD 21217	
	يا رق		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
À	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen	- 1.	VICE					
	*	ner	Sequentially list conditions, if any, leaung to innerstrate cause. Enter Undertying Cause (Disease or injury	Due to (or as a nonsequen	nce of):						
o,	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):						
58760,	ficate be physicial sthe bu	edicai									
O. Box	The law requires that the death certifi tte has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	eath 3□E	ctopic pregnancy Other (specify)			23d. Date of d Month	23d. Date of delivery Month Day Year	
م	quires that f n signed by uld be detac	by	Part II. Other significant conditions con	tributing to death but not resulting	ng in the und	erlying cause give	en in Part I.			to the cause of death? Probably 4 □Unknown	
Il Records,		Completed						24a. Was a autops perform 1 🗌 Yes	med? prior to	autopsy findings available o completion of cause of ? es 2 □ No	
Vital	sicien: certific rector.	o Be	25. Was case referred to medical examiner?	lospital:	NOutpatient	3□ DOA Oth	or	th <i>(Check only or</i>	ence 6 Other (Sp	pecify)	
of	Jing After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Injun Worl			ow injury occurred	,	
Division	P the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,	
	To the Hospitel or Atwithin 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physical Control 2 Medical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the d rred at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)	
2	To the within 2 To the complet	Me	29b. Signature and title of certifier	- lan		29c. Licens		2	29d. Date signed (Ma	nth, Day, Year)	
			30. Name and address of person who co			rint)	73780		5/50/	1	
	St	ate	Farhan Ali Bon 31. Date filed (MSCE Payo Year) 201	Secours Hospit	tal Ba	Itimore,	Md 21217				
,	Regist		2EL 0 0 501	- Central							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1perpHYS, G932, 10/26/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Caroline Ne1son 2. Date of Death 3. Time of Death -900lina Year 10:30PM Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FORESTVILLE FORESTVILLE NURSING & REHAB 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours NOV 16 1935 VIRGINIA **Director** 1 ☐ M 2 🛣 F 76 578-52-4467 Usual Residence of Deceden 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland Director 1 Yes 2 x No DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20018 USA 3298 FT. LINCOLN DRIVE # 425 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working should be filed within 72 in and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 12th HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JOSEPHINE SCOTT CALVIN TURNER permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any Injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 8th ST N.W. WASHINGTON, DC 20019 JOHN C. TURNER/BROTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State RIVERDALE CREMATORY 9/6/2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final disease or condition Pnysician/ NOOS ancreo Medical resulting in death) Due to (or as a consequence of): Examiner an cer etastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence of): ng physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year detached 9 Unknown Division of Vital Records, P.O. á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 å 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed the Hospital or Attending Physicien: The thin 24 hours after death.

the Funeral Director: After this certificate by the Funeral Director, After this pagingletely filled in by the funeral director, paging 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Teath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 400 Aviation 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T934 SYEN MAHBOOB alen 11.20 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 5 **Physician** JUDITH J 8.30 PM NETZER 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 60 214 62 8903 Maryland July 27,1952 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 X No Baltimore Director Maryland Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò death with ms 23a or must be r 3200 Foxglove Lane 21220 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If them 27 is marked other them." Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo White 1 ☐ Yes 2X No Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Housewife** Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Leonard Foltzer Doris Gertrude DeBaufre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Dea Netzer (Daughter) 1729 Earhart Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Inc. 9/6/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Bruzdzinski Funeral Home P.A 1407 Old Eastern Avenue Esse

23a. Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIORESPIRATORY **Physician** /Medical Due to (or as a consequence of): **Examiner** METASTATIC LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 4 Unknown 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred I Director: After to ad in by the funer 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

GEORGE 31. Date filed (Month, Day, Year) SEP 0 6 2012

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number RES ODU 29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

SEPTEMBER 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5, per INF, 932 10-22-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar 28415 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ERT VEIOUNGER Physician/ Month August 7:04 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Riderwood Assisted Living Social Security Number 566–14–5259 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 ፟ M 2 □ F Months Days Hours Min. Callifornia Director 89 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3160 Gracefield Rd RD-511 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. <u>6</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) healthcare doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Christine Frances Christiansen Arthur Waler Neidlinger 19b. Maijing Address (Street and Number or Bural Route Number, City or Town, State, Zio Gode, 10709 Cottonwood Way; Columbia, MD 21044 19a. Informant's Name/Relationship (Type, Print) Mark Neidlinger - son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Signature of Funeral Service Ronal d 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Part 1. shock, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) GRACEPIELD RD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Estelita H. Olimpo September 6:35 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Director 576**-**13-6171 1 🗆 M 2 🗓 F 92 3. Philippines show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 뮺 No Maryland Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9130 Ivanhoe Road 20744 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Filipino 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Balbino Homeres Cesaria Bahia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonila Olimpo-Henson/daughter 9130 Ivanhoe Road Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o' 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc, 09/05/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc <u> 299 Frederick Road Baltimore, Maryland 21228</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition noumono Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin attending physician and for use as the burlal-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death 1 Yes 2 9 Unknown Month Day ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Doknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page performed' 2 No Yes 2 XX 1 Yes 25. Was case referred to medical examiner? Be **Division of Vital** 26. Place of Death (Check only one) Hospital Other: 2 13478 1 Tes မ 1 Pripatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Chatural
2 Accident
3 Suicide
4 Homicide 5 Pendina 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Vennia Perkey 12:05 P M September 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 600 Rider Place Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 8. Date of Birth 223 46 9261 Hours (Month, Day, Year) Director 74 1 □ M 2 🔀 F Oct.24,1937 Tennessee 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code .s 23a o. • must b 10g. Citizen of What Country? Funeral 600 Rider Place 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Completed 3 XWidowed 4 ☐ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) event, the Me Elementary/Secondary (0-12) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N College (1-4 or 5+) Cashier Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Howard Bostian Laura Frances Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie E. Perkey (Daughter) 836 Flintlock Dr. Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ŏ cemetery, crematory or other place. 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Department of Important: If any injury or Holly Hill Mem. Garden's 9/7/2012 4 Donation 5 Other (Specify) Baltimore, Maryland Sign Aure/of Funeral Service Licenses 22 Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old <u>Fastern Avenue</u> Essex 0 Maryland 21221 23a. Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciun/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atten 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completely filled in by the funeral director, pag 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

DHMH 17 Rev 06-2011

State

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 0 6

herden Muhen, M

Sheldon Milner, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9110 Philadelphia Rd

29d. Date signed (Month, Day, Year) 09/06/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28418 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John 3:30p Paul Puciato 09703/2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Catonsville Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 212-10-5490 93 Director 07/15/1919 1 X M 2 □ F MD show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2150 Harman Ave. 21230 **USA** 11. Marital Status 12. Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 A Yes 2 No.
If Yes, Give 1942–1945
Year or Dates. 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working <u>[if</u>e._DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Welder BGE Power Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Puciato George ပ Anna Matusewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Puciato / Son 2150 Harman Ave., Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory 09/05/2012 Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA 1 le M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

And Immediate Cause (Final) Immediate Cause (Final Physician/ Onset and Death T C & disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month been signed by the a should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be lirector, page 2 s autopsy perform Yes 2 No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 I After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director; Aft 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F only one) 29b. Signature and title of certifier 00059107 M-D

DHMH 17 Rev 06-2011

State Registrar VICTORY SPRINGS INC, 211) BUSINESS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c. perFH. G931.9/6/2012 WS
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Aug 15, 2012 Year Floyd Prevost 1453 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death

Montgomery Silver Spring **Holy Cross Hospital** Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) (Month, Day, Year) Jan 6, 1945 Days Hours Min 1 M 2 D F Director 465-72-5102 67 Yrs Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. Count 10d. Inside City Limits 10c. City, Town or Location Director Yes 2 □ No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 U.S.A. 12501 Buckley Drive 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 X Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Law Office Lawyer 12 Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ٥ **Ernest Prevost** Mary Prevost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
40-1 Bergenridge Road, North Bergen, NJ 07047 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau Vincent Harris 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State TE Bunal 2 Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory Aug 25, 2012 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) Catonsville 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 d Funcial Service Lice see 21. Sign Sil Bunil Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, a Septic Shock days Medical resulting in death) Examiner Perforated Ulcer 1 month Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a nonsequence of Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) signed by the attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Colon Cancer 1 🗌 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X** No မြ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending work? 1 Yes Accident 2 \square No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2018 8/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Betsy Ballard 10301 Georgia Avenue, Silver Spring, Md 20902 31. Date filed (Month, Day, Year) SEP 0 6 2012 State

HMH 17 Rev 06-2011

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical Examiner	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions com A A A A A A A A A A A A A A A A A A A	4 Pregnant at time of death 5 Unknown	26. Place of Death (Chec	1 🔏 Yes 24a. Was an autopsy perform 1 □ Yes 2 k only one)	24b. Were autropior to codeath? Solved 1 Yes Code	the cause of death? obably 4 Unknown opsy findings available ompletion of cause of 2 N-No					
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The law requires that the death cert ate has been signed by the attendir page 2 should be detached for use	Be Completed by Physician/	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions condi	Bc. If yes, outcome of pregnancy 1	Other (specify) underlying cause given In Part I. 26. Place of Death (Chec	1 🔏 Yes 24a. Was an autopsy perform 1 □ Yes 2 k only one)	Month acco use contribute to s 2 □ No 3 □ Proprior to c death? Solution 1 □ Yes	the cause of death? obably 4 Unknown opsy findings available ompletion of cause of 2 N-No					
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e death certificate be execute the attending physician and hed for use as the burial-tran		that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Bc. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5				*					
certificate be execute anding physician and use as the burial-tran		that initiated events resulting in death) Last Output	Bc. If yes, outcome of pregnancy			23d. Date of deli	very					
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후 구 등	15.1	Cause (Disease or injury										
sit sit	Ë	cause. Enter Underlying	Due to (or as a consequence of):			1						
Examiner	e.	Sequentially list conditions, b										
Medical		disease or condition resulting in death)	. Due to (or as a consequence of):	Coranov	<u>ua</u>		Onset and Death					
23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
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nit. Pagrartment ortant injury o		4 ☐ Donation 5 🗷 Other (Specify)	In state		ate Anato	omy Board						
of Healt of Healt fitem 2 r other		20a. Method of Disposition	20b. Place of Dispo	osition (Name of								
2 shoul th and I 27 is ma trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara I Privette - wife 40 Robin Hood Rd: Havre de Grace, MD 21078										
i be filed within fental Hygiene. rked other tha tic event, the N	다 B	17. Father's Name (First, Middle, Last) 1	ınk	18. Mother's Nam	e (First, Middle, Ma	aiden Surname) UNK						
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irs after ural", oi I Exami		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:		Specify: White						
death v items ner mu		Tribana Status		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer						
/ith the 23a or st be n				10f. Zip Code 21078	10	ng. Citizen of What Cou USA	untry?					
Maryla 28a-f s otified	irect	MD Harford	Havre de	e Grace			1 🗆 Yes 2 🖾 No					
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or La		Feb 16,	1934	10d. Inside City Limits					
Director		232-52-7784		Months Days Hours Min.	(Month, Day,)	Year) Cou	nplace (State or Foreign entry) unk					
<u> </u>		8 Chestnut Drive	7 Age (In ure Inst hirthday)			Harford						
			reet and number)	4b. City, Town, or Location of Death		4c. County of Death						
Physicia	ın/						3. Time of Death 4:00 AM					
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at a long.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Physician/ Medical Examiner 1. Decedent's Name (First, Middle, Last) William Privett 4a. Facility Name (if not institution, give st 8 Chestnut Drive 5. Social Security Number 232-52-7784 Usual Residence of Decedent 10a. State 10b. County MD Harford 10e. Street and Number 8 Chestnut Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) 17. Father's Name (First, Middle, Last) 18. Widowed 4 Divorced 19. Informant's Name/Relationship (Type Sara J. Privette 20a. Method of Disposition 1 Burial 2 Cremation 3 Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type Sara J. Privette 20a. Method of Disposition 1 Burial 2 Cremation 3 Father's Name (First, Middle, Last) 10a. Street and Number 15. Decedent's Edu (Specify only highest grade) 15. Decedent's Edu (Specify only highest grade) 16a Divorced 17b Secondary (0-12) Unk 17c Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type Sara J. Privette) 20a. Method of Disposition 1 Burial 2 Cremation 3 Father (Specify) 21. Si Sara J. Privette 22a. Part 1. Exter the disease, or complication of the properties	Physician/ Medical Examiner Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) William Privett	Physician/ Medical Examiner 1. Decedent's Name (First, Middle, Last) William Privett Examiner 8. Chestnut Drive Funeral Director Funeral Route Mamber of Purel Director Funeral Route Mamber of Purel Route Number Physician/ Medical Examiner Registrar Certificate of Death Registrar Certificate of Death Mortial August 26 2012 2. Date of Death Mortial Mortial Mortial August 26 2012 4c. Country of Death August 26 2012 4c. Country of Death Harfort Beneral Director Funeral						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 28421 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day August 15, 2012 **Medical Examiner** 2111 hrs Jenna Price 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4331 E. Lombard Street Baltimore 5. Social Security Number 1111 k 6. Sex If Under 1 Year I if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk **Funeral** 7. Age (In yrs. last birthday) Months Director July 10, 1970 42 1 M 2 X F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No s 23a or 28a-f show 28a-f show Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 4331 E. Lombard St. 21224 USA Funeral 11. Marital Status UNK 12. Was Decedent Ever in U.S. Armed Forces? UNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: White 1 Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unkCompleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) unk æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore St; Baltimore, MD 21223 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 21. Signature of Funeral Service Licens : 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line Between Onset and /Medical Death aAlcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical \square AMENDED 23a, pt.II, 27, 28a-f, per me, g933 11-29-12 sm X UNPENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for 9 Unknown signed by the the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism, acute pyelonephritis Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural unknown Pending 1 Yes 2X No Director: fd 21:00 pm fd 8-15-12 To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) 4331 E. Lombard St. Baltimore, MD. determined (Specify) Multi-Family Apt. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 16, 2012 COME eted cause of death (Item 23a) 30. Name and address of person who compl Day 6 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month aen e rowe à ci 15 ugus Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ohns Hookins timor HOSPITA Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 04/27/1942 Days Min. Director 216-40-0590 1 X M 2 D F NY 70 Yrs Usual Residence of Decedent in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 524 North Charles Street #305 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Arundel Masonry Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Eugene Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 N. Belnord Avenue Baltimore, MD 21205 Taves Powell / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 09.11.2012 Cremation Ctr of MD Hanover, MD ature of Funeral S 22 Name and Address of Facility John L. Williams Funeral Directors, P.A. 4517 Park Heights Avenue Baltimore, MD 21215 tt . Enter the disease, or complications that caused ock, or heart failure. List only one cause on each line. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burlal-transi Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes No 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral di 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowled at death occurred at the time, date and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 0699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SENNIFER KANAKY 1800 OF IE Orleans + more 31. Date filed (Month, Day, Year) State Registrar's Signa SEP 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 28423

Gerald Poindexter	1-	For State	State	of Maryla		oartment e <i>rtificat</i> e			d Men	ital Hy		Reg. No	20	12	2842
Physician Medical Examine	1 1	Decedent's Name (First, Gerald Terre			er						2. Date of De Month Septemb	ath Day	Year	3	3. Time of Death 0825 hrs
	4	a. Facility Name (if not ins 4204 Groveland A		street and nur	mber)			City, Town, or Baltimore	Location	of Death			c. County of I	Death	
Funeral Director	5	Social Security Number 217–11–0836	6. Se	х (м 2 F	7. Age (In yrs	s. last birthday	· —	f Under 1 Year Months Days		er 24Hrs. s Min.	8. Date of B		F	9. Birth oreign	olace (State or etry)
Maryland 28a-f show any d at once.	1	Jsual Residence of Decedors Oa. State 10b. Co		'a	10c. Ci	ty, Town or L		imore						- 1	Od. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho motified at once		Oe. Street and Number 4204 Grovel	and Av	enue			10	Of. Zip Code	1215			•	tizen of What	Countr	y?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heafth is and Mental Hygie one. Important If item 73 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Commisted by Finneral Director	اج		_	If Yes, Give Year or Dates:	rces? 2 X No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, e White, e 1 Yes 2 No specify: Specify:B1						etc.	n Indian, Black,		
5-0036 ed within 72 hours tygiene. other than "natus the Medical Exam Commilered		15. Decedent's Education Elementary/Secondary (12	0-12)	ly highest grad College (1-		durin	ng most	of working life.	ical	use retire Tecl	ed)	As	Kind of Busin		
21215-0036 outlibe filed within 7 d Memal Hygiens 8 marked other than itic event, the Medica TO Be Comple	B	7. Father's Name (First, M Roland Thoma 9a. Informant's Name/Rela	as Par			19b. Ma	ailing Ac	dress (Street	Bark	bara	(First, Middle, Ann Poural Route Nu	oind	lexter	State, Z	(ip Code)
re, MD 1 and 2 sho Health and fitem 27 is r traumati	2	Barbara Poin			201		sposition	olfield		nue I	Baltimo Date	•	MD 21		
Baltimore, pemit. Pages 1 ar Department of Hee Important: Uite	- 1	1 X Burial 2 Crer 1 Dongtion 5 Ott	er Specify:	_	m State T:	rinity	Cen		of Facility		08.2012			re,	MD
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Medical Examiner		mmediate Cause (Final di or condition resulting in de	sease a.	Asphyxia Due to (or as a	consequence	of):								- 1	Death
ted Insit Examiner	iii d	Sequentially list conditions f any, leading to immediate ause. Enter Underlying C Disease or injury triat inition	ause c.	Hanging Due to (or as a											
6 be executed ysician and burial - transit		UNPENDED	d.	AMENDED										\dashv	
D. Box 68760, the death certificate be by the attending physicisched for use as the buring Physician/Med	23	F FEMALE: 8b. Was decedent pregnar past 12 months?	nt in the	1 Live bi	int at time of	2	Fetal of Other	leath 3 [Ectopio	c pregnar	ncy	23	3d. Date of de Month	livery Da	y Year
s, P.O. Beires that the de signed by the 1 be detached for the by the 1 by Phy	3	Part II. Other significant c	onditions	contributing to	death but no	t resulting in t	the unde	erlying cause g	iven in Pa	art I,					e cause of death?
Records: The law requiricate has been r. page 2 should		5. Was case referred to m	edical		-			26 Place	of Death	(Check o	1 Yes		prio dea	r to cor	psy findings available npletion of cause of 2 No
of Vital g Physician: ther this certificated in Crossics To Be Crossics		examiner? 1 Yes 2 No.	įΗ	ospital: 1 Ir	patient 2	ER/Outpat		DOA		Nursing	Home 5				Scene
Division of spiral or Attending P nearl Start death. After filled in by the funera Centrification:		1 Natural 5 2 Accident	Pending Investigation	FOUND: Sep 3, 20	Day,Year) 012	FOUND: 0822 hrs	:		′es 2 ✓	No S	Subject fou	ind ha	anging		Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the i	- 12	Suicide 6 4 Homicide 9a. Certifier 1 Certify	Could not be determined in Physicia	pe	Multi-Fan	nily Apt.				4	or Town, 1204 Grovela	State) and Av	enue, Baltir	more, I	MD
To the Hos within 24 h To the Fur completely		0110011 0111)	i Examiner:	On the basis o	f examination	_			, death oc			and pl		to the	cause(s)
		ane 52						O.C.N					ptember 4		
<i>></i>		0. Name and address of p Ana Rubio M.D., I	Ph. D.	Assistant M	ledical Ex	aminer 9	900 W	. Baltimore	Street,	, Baltim	ore, MD 2	1223			
Stat Registra	-	1. Date filed (Month, Day,	6 201		gistrar's Signa	ature.	ex								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28424 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOYCE LOUISE PARKER-SMITH AUGUST 2012 12:40₺ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 246-54-5475 NORTH CAROLINA Director 1 M 2 TF 2-24-1931 81 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD. N/A BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1050 E. 33rd ST 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 ▼ No 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced If Yes. Give BLACK Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) COMPANION MEDICAL other treumetic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ permit. Pege 1 end 2 should be Departmant of Haeith and Men Importent: If Item 27 is merke eny injury or other treumetic VANIS PARKER FLOSSIE EURE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRISH KIRBY-NOAKES (DAUGHTER) 5642 WHITBY RD. BALTIMORE, MARYLAND 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 Cremetion 3 Removal from State DULANEY VALLEY CEM. 9-4-2012 4 Dona on 5 Other (Specify) TIMONIUM, MARYLAND D. 21. Signature Funeral Service Nicensee JONATHAN HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate Cause (Final carditomy Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir sicien and buriei-transit that initiated events resulting in death) Last Due to (or as a consequence of): physicien s the buriel Physician/Medical 98 attanding p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year Pregnant at time of death ed by tha a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ceta has l paga 2 s autopsy 2 No 1 Tes funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attanding 1 Natural 2 Accident 3 Suicide 5 Pending thours after death.

unerel Director: After ally filled in by the fur 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital o within 24 hours af To the Funerei Di compietaly filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie ess of person who completed cause of death (Item 23a) (Type, Print) Marratt HAMES m 6701 ST PHISON MY

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 3, 2012 2:35 A Virginia Agnes Ramsay Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 13924 Blair Stone Lane Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 382-30-7322 **Director** 1 M 2 XF Mar. 7, 1933 Michigan 79 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 20906 United States 13924 Blair Stone Lane "natural", or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Consulting 12 Clerk Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ည Jessie Saffel Malone Harvey item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a 13924 Blair Stone Lane, Silver Spring, MD 20906 Raymond Ramsay, spouse 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or of once. Baltimore Crematory at Loudon Park 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/14/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 101564 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Examiner Due to or as a consequence of as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) for in the past 12 months?
1 Yes 2 X No Day Month Year be detached the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial fibrillation 1 Yes 2 No 3 Probably 4 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 **X** No Other: မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending s after death.

I Director: Al 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) September 5. 2012 D39793 completed cause of death (Item 23a) (Type, Print) M.D., Olney, MD

Registrar DHMH 17 Rev 06-2011

State

Christopher Mayes,

SEP 0 6 2012

31. Date filed (Month, Day, Year)

18111 Prince Philip Dr., #207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan		artment of F <i>tificate of L</i>		d Mental Hy	giene	112	28426	
			Registrar 1. Decedent's Name (First, Middle, Last)		00,	lineare or .	Jean	2. Date of De	ath		3. Time of Death	
	Physicia Medic		Francis John Rona					Augus	t 25	2012	9:00 A ^M	
	Examin	er	4a. Facility Name (if not institution, give st 5769 Robin Rd.	reet and number)		4b. City, Town, o Deale	Location of De	eath		nty of Death	undol	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 F		th	9. Birthp	place (State or Foreign	
	Director			M 2 □ F 80	Yrs.	Months Days	Hours M	in. (Month, Da		Maga		
	and show at	٥	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation		June 29	, 1932		achusetts Od. Inside City Limits	
	Maryla 28a-f otified	irect	MD Anne A	rundel D	eale						1 Yes 2 🔀 No	
	n with the	Funeral Director	10e. Street and Number 5769 Robin Rd.			10f. Zip Code 20751			10g. Citizen d USA		itry?	
9000	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 1 Never Married 2 X Married 3 Widowed 4 Divorced	1 163 2 110	55-	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🙀 No	ın, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036	iled within 72 hou Il Hygiene. other than "nati vent, the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4 or 5+)	(Give k life. DC	lent's Usual Occup kind of work done of D NOT use retired)		vorking	16b. Kind of	Business/Inc	_{dustry} unk	
land ?	l be filed w lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Francis John Ronar					Name (First, Middle, Maiden Surname) e Florance Connelly				
Mary	d 2 should be file alth and Mental I 27 is marked c r traumatic eve		19a. Informant's Name/Relationship (Type Mary R. Ronan - V					Rural Route Numbe	r, City or Town, State, Zip Code)			
imore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify)	Removal from State	lace of Disposemetery, crem	sition (Name of natory or other plac	re)	Date	20c. Locatio	on - City or To	wn, State	
Balt	permit. Departr Imports any inji		21. Signatur f Funer ervic I. A. dee	dé, Director	22.			State Ana re St; Ba	-		21201	
~	Ph, sician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Sause (Final disease or con thin							,	Approximate Interval Between Onset and Death	
1	Medical Examiner		Interval Betwork or heart failure. List only one cause on each line. Immediate Seuse (Final disease or confit in resulting in death) Sequentially list conditions, b.									
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
092	te be exec nysician ar he burial-t	edical E	resulting in death) Last	Due to (or as a consequent	ience of):							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ĮĚΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of d 9 Unknown	l death 3	Ectopic pregnand Other (specify)			23d. Date of delivery Month Day Year			
ds, P.0	requires that the been signed by should be deta	by	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.			acco use contribute to the cause of death? s 2 \(\sum \) No 3 \(\sum \) Probably 4 \(\sum \) Unknown		
Division of Vital Records, P.O.	The law rec ate has bee page 2 sho	Completed								b. Were autop prior to con death? 1 ☐ Yes	osy findings available mpletion of cause of 2 No	
ita	ician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:		Oth	ace of Death (C	heck only one)				
of V	g Phys er this eral di	e: To	1 ☐ Yes 2 ☑No Ho	1 Inpatient 2 I	28b. Time of	t 3 DOA 28c. Injun	4 U Nursing	28d. Describe h				
sion (ttending death. ctor: Afte y the fun	Certificate:	1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	(Month, Day, Year) 28e. Place of Injury - At hor	injury	M 1 🗆					Doube Attaches	
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2		4 Homicide determined 29a, Certifier 1 Certifying Physic	building, etc. (Specify))		data and place	28f. Location (S City or Tow	m, State)			
	the Hos hin 24 hd the Fun apletely	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of examination Practitioner: To the best of m	and/or investi	igation, in my opinio death occurred at t	n, death occurre he time, date an	ed at the time, date a	nd place, and	due to the cau	use(s) and manner stated.	
	P N P S		29b. Signature and title of certifier Thomas 25	mith mo		29c. License			29d. Date sign	ned (Month, D	ay, Year)	
	1		30. Name and address of person who con Thomas JSmith	npleted cause of death (Item	23a) (Type, P	rint) Bla	6 c/c 3	oife St	Bolti	norc	21287	
	Stat Registra	te ar	Thomas JSm. 42 31. Date filed (Month, Day, Year) SEP 0 6 2012	62. Registrar's Sign to	ure far	الما						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day SEPTEMBER 2 2012 RUDOLPH 02:50P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day. Funeral 9. Birthplace (State or Foreign Hours (Month, Dav. Year) Country Director 213-20-5367 1 | M 2 | X F 100 Yrs. 09/17/1911 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Importent: If item 27 is marked other then "nature!", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3211 CLARKS LANE, 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 SALESPERSON CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ WITTIK REBECCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL KELLY/GREAT NIECE LACOSTA COURT. TOWSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 09/05/2012 WOODLAWN, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 201117 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA Nospill 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tyes 2 🗌 No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie

State Registrar 30 Name and add

31. Date filed (Month, Day, Year)

6701

ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 tem 20b per fh e931 9-6-12 vt
State of Maryland Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 3 2012 RUSSEL 08:30AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 725 MT WILSON LANE, #510 PIKESVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Hours **Director** 213-30-8622 1 🗆 M 2 🗓 E 96 01/31/1916 **GERMANY** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 725 MT WILSON LANE, #510 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14 Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 🛭 Widowed 4 🗆 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) TRAVEL AGENT TRAVEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Mental ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. CHAIM ZIPSER BERTHA KLEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT RUSSEL/SON 801 KEY HIGHWAY, #T-31, BALTIMORE, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Chevra cranavasheChesed 4 Donation 5 Other (Specify) 09/05/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mars Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Atheroacteratic cardiovascolor discose Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 05/00/00/05/15 2Q15 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Year Day 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

29b. Signature od title of certifier

31. Date filed (Month, Day, Year)

amary 5. Sobel, UD

Registrar DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tamany 5. Sobre 1, 400 21 Crossivands Drive #402 Cwing Mills, 40021117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:20 P M RUTH SEPTEMBER RUBEN 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Director 219-28-3564 1 M 2 X F 80 06/05/1932 MD 28a-f show 10a, State 10b. County with the Maryland 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Tes 2 No PALM BEACH PALM BEACH GARDENS 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be Funeral 162 SUNSET BAY DRIVE 33418 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or i Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4 or 5+) 5+ d other t TEACHER PRE-SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Health and Mental H rtant; If item 27 is marked of ijury or other traumatic ever မ MORRIS CAPLAN MARTAN WEINBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELDON RUBEN/HUSBAND 162 SUNSET BAY DRIVE, PALM BEACH GARDENS, FLBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o X Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 09/05/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner **EMPHYSEMA** Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) LUNG CANCER Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Ves sate has been signated bade 2 should be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 1 Yes 20 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2023 No မ inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 10 Natural injury work? 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 🗌 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

12 v

103/2012

Babak Pirouz 8600 Old Georgetown Rd. Bethesda, MD, 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) SEP 0 6 2012

32. Registrar's Signature

State

Registrar

09/03/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Dea 3. Time of Death Physician/ SMITH Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Months Hours Director 1 🗆 M 2 🗓 578-32-6544 1922 South Carolina 89 Dec. 3, Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1

Yes 2 □ No MD Prince George's Landover 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r Funeral 20784 USA 6509 Parkwood Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Government and Mental Hygien is marked other th Accountant 2yrs+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Fields Joish Howell Department of Health and Important: If item 27 is m. any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniele Howell/Niece Locust Avenue Monessen, VA 15062 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 09-07-2012 Brentwood, Maryland Signature of Funeral Service License 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Naphney N. 7474 Landover Rd. Hyattsville, MD 23a. Part 1. Exerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ TUE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, each growth to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has k autopsy performed' 2 No 1 Yes Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 E M6 ျှ 1 Yes ER/Outpatient 3 DOA 1 Deatient 2 28a. Date of injury (Month, Day, Year) 27. Manner 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the le within 2 To the le Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O Name and address of person (Q)leath (Item 23a) (Type, Print) HWY ANNAPOCTS, M.D RIEVE efense

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1345 M OBENDA SCOTT 207 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 5406 GALLOWAY DRIVE OXON HILL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Director 098-30-6347 1 🗆 M 2 🗶 F JUNE 27 1931 WASHINGTON, DC 81 Usual Residence of Decedent 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S OXON HILL 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 5406 GALLOWAY DRIVE 20745 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc ò 2 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) vgiene. ver than ' Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER 12th PRIVATE other 1 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDWARD V. FISHER BERTHA GREENWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH SCOTT/HUSBAND 5406 GALLOWAY DRIVE OXON HILL, MARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9/6/2012 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) VETERANS CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician. Arteriose disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, Exam Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death in the past 12 months? 1 Yes 21 No Pregnant at time of death 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page certificate 1 Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death.
I Director: After the din by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗌 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06353 State of Maryland / Department of Health and Mental Hygiene Amber Deanna Stanley 1. For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day August 22, 2012 2305 hrs Medical Examiner Amber DeAnna Stanley
4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro Prince George's 114 Chartsev Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Foreign Wash., DC Hours Min. Months Davs Director 1 M 2 02-08-1995 219-43-7.005 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny. 10a. State 1 XYes 2 No 28a-f show Upper Marlboro Prince Georges hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number USA 20774 114 Chartsey Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 1 Yes 2 No specify: 4 Divorced If Yes, Give Year Specify: Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filted within 72 hours after
Department of Health and Mental Hygene.
Department If item 27 is marked other than "natural",
injury or other transmatic event, the Medical Examiner. Black δ 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Student 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony David Stanley

19a. Informant's Name/Relationship (Type, Print) Irma Phifer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11460 Dunloring Place, Upper Marlboro, MD Anthony Stanley
20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
t. Lincoln
emetery 1 X Burial 2 Cremation 3 09/01/12 | Brentwood, MD 4 Donation 5 Other Specify 22 Name and Address of Facility Freeman Funeral Services gnature of Fulneral Service Lice Pirt I. Enter the disease, or college that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 20748 Approximate Interval Physician Between Onset and falure. List only one cause on each line /Medical Death Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial 28D, PER ME G931 9.5.12 TRT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? performed? ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 28a. Date of Injury FOUND: 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Subject SHOT FOUND: 1 Natural 1 Yes 2 ✔ No Pending the Aug 22, 2012 2223 hrs 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 114 Chartsey Street, Upper Marlboro, MD determined (Specify) Single Family Home 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OPIGNAL

30. Name and address of person who completed cause of death (Item 2/3a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

August 23, 2012

Raymond Savage

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible		
State of Maryland / Department of Health and Mental Hygiene	2012	28433
Certificate of Death	2012	20700

		1- For State Certificate of Death Reg. No.												
Physici ledical Exami		1. Decedent's Name (First, Middi Raymond Sava					-			Date of De	eath Day	Yea	r	3. Time of Death 2313 hrs
		4a. Facility Name (if not institution	n, give street and no	ımber)		4b. C	ity, Town, or Lo	ocation o		August 2	_	c. County o	of Death	
ř'		Mercy Hospital		,,			altimore							
Funeral Director		5. Social Security Number 215 – 86 – 7243	6. Sex	7. Age (In yrs. 36			Under 1 Year onths Days	If Under	r 24Hrs. Min.	8. Date of I	,		Foreign	hplace (State or n untry) MD
yland -f shnw any once.	tor	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number		10c. Cit	y, Town or Lo Ba	ltir	More	_			400	tizen of Wh		10d. Inside City Limits 1 X Yes 2 No
the Mar 3a nr 28s	Director	122 South Ca	rrolltor	a Ave			21223				log. Ci		USA	uy?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menal Hygienei. 27 is marked other than "natural", or items 23a nr 28a-f abn cart is the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div 15. Decedent's Education (Spe	arried Armed F 1 Yes orced If Yes, Give Yes or Dates:	2 X No	1[lf Yes, sp	cedent of Hispa pecify Cuban, I 2 X No	Mexican, s <i>pecify:</i>	Puerto Ri	can, etc.)		White Specify:	, etc. Whi	
hin 72 hou e. than "nat	Completed	Elementary/Secondary (0-12)	during most of working life. DO NOT use retired)											ntractor
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than	Con	17. Father's Name (First, Middle,	Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)											
2121(uld be fil Mental F marked	Be	Robert Savage												
D 21 should and Me	٩		Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,											
두 명품 용취		20a. Method of Disposition	aricela Raymundo Wife 122 South Carrollton AVe Baltim Method of Disposition Date 20c. Location - Ci											
MOF Pages 1 tent of 1 int: If i			Burial 2 X Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify: Atlantic Crem 9/6/12 Glen Bu											ie MD
Balti permit. Departri Imports injury n		then !	DU-			Chon	nasAll	enP	Simp A 70	90 R	ty idg	Crem e Rd	& Ha	Fun Serv nover MD
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Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Upper (Gastroin consequence		na1	Hemorrh	nage						Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	of):								i)	·
ed Isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of);									
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760, ficate be exe g physician the burial	ı/Medical	IF FEMALE:		outcome of pre		71-				12 02		d. Date of	delivery	
ecords, P.O. Box 68760, he law requires that the death certificate be are than been signed by the attending physicis age 2 should be detached for use as the burit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Univ	e 1 Live b	oirth nant at time of d	2	Fetal de Other (eath 3 Specify)	Ectopic	pregnanc	y 		Month	D	ay Year
the dear	Phy	Part il. Other significant conditi	9 Unkn		resulting in th	e underl	vina cause give	en in Par	† 1	23e Did	tobacco	use contrib	oute to th	ne cause of death?
P.O.	Ā	Heroin Use					,			1	_			ably 4 🗹 Unknown
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of Vital Records, ng Physician: The law require this certificate has been si meral director, page 2 should t	Be Completed									peri	opsy formed? 2 1	d	eath?	ompletion of cause of
Vital ysician: his certifi director,	Be	25. Was case referred to medical examiner?	- Hospital:		7		26.Place of	thes =			_			
f Vi Physi er this	ျ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpation 28b. Time of		DOA 28c. Injury		Nursing F		Reside	ury occurre	Other:	
Sion of Attending Ph r death, ector: After t	ation:	1 X Natural 5 Pend	(Month	, Day,Year)	200. 11110	or injury	1 _ ` `	s 2		d. Describe	o now my	dry occurre		
VIS Ir At Pired in by	Certification:	3 Suicide 6 Could	3 Suicide 6 Could not be determined Coperation (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number of Or Town, State)										r or Rur	al Route Number, City
Di To the Hospital 1 within 24 hours at To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Prone) 2 Medical Example Control Certifying Prone	nysician: To the besing and manner s	of examination										
	Me	29b. Signature and title of certifie		a in			29c. License r O.C.M.					Date signe		th, Day, Year)
1 park		30. Name and address of person	•	•		Baltir	more Street	t. Baltir	more. M	D 21223			_	
St	ate	31. Date filed (Month, Day, Year)												
Regist	rar	SEP 0 6 201	7 /2	1 1.	Dark									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edward Fulton Spro	OUSE 1- For State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Realth 2012 284.										
Physician/	Registrar 1. Decedent's Na	ame (First, Middle,Las	it)		incate of	Death		2. Date of D	Reg. No. 🔏	201	3. Time of Death	
Medical Examine	Edward	Fulton	Sprous	e				Month August 3	31, 2012	Year	1635 hrs	
	4a. Facility Name	(if not institution, giv	e street and num	ber)		4b. City, Town, or	Location of De	eath	4c. Cour	nty of Death		
		hington Blvd Lo				Elkridge			Howa			
Funeral Director	5. Social Security 219 – 30	_4013	9X 7]M 2F	7 6 Age (In yrs. I	ast birthday) Yrs	Months Day		_	Birth(MM/DD/Y) 27/1935	Familia	thplace (State or in untry) MD	
	Usual Residence	of Decedent										
d buw any	10a. State MD	10b. County Howard		1	Town or Locat						10d. Inside City Limits 1 Yes 2 No	
the Maryland a ur 28a-f shuw tified at ouce.	10e. Street and I	 ∤umber				10f. Zip Code			10g. Citizen of	What Coun		
the M	6620 W	ashingto	n Blvd	Lot#	7	21075	5		USA			
r death with or items 23 r must be no	11. Marital Statu	rried 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian, Black, White, etc.		
fter des 17, or i 17 FUI	3 Widowed		1 Yes	2 X No		Yes 2 X No			Specif	v: Whi	te	
ours after atternal" tamine	15. Decedent's	Education (Specify or	or Dates: nly highest grade	completed)	16a. Deceder	it's Usual Occupa	tion (Give kind		16b. Kind of			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shun injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Se 12	condary (0-12)	College (1-4	or 5+)	_	ost of working life ager	E DO NOT use	retirea)	Rest	caura	int	
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 127 is marked other than umartic event, the Medical TO Be Compile	17. Father's Nam	e (First, Middle, Last)				Ī		me (First, Middle				
2121 Jid be fil Mental I marked event,	L	Name/Relationship (T		-	19b. Mailing	Address (Stree	_	y Diffe			Zin Code)	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	4 Donation	5 Other Specify:		At		c Crem		/6/12	GlenE			
Ball permii Depar Impo	21. Signature of	uneral Service Licen			The	omasAll	s of Facility of enPA	Simplic 7090 Ri	city Cr dae Rá	cem &	Fun Ser	
Physician		the disease, or comp		sed the death.							Approximate Interval Between Onset and	
/Medical Examiner	Immediate Cause or condition resu	(Final disease a.	Contact Gun								Death	
	Sequentially list		Due to (or as a c	onsequence of	·):							
liner	if any, leading to	immediate derlying Cause	Due to (or as a o	onsequence of	r):							
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certification certification cian	23b. Was deceder past 12 mont	hs?	1 Live birt	h nt at time of de	ath -	taldeath 3 oner (Specify)	Ectopic preg	gnancy	Month	ı D	ay Year	
O. Box 68760 that the death certificate by the attending physical charched for use as the by by Physician/Me by Physician/Me	1 Yes 2	No 9 Unknown	. —		3 [Oti	ner (<i>Speary</i>)						
i, P.O. ires that the signed by I be detach	Part II. Other sig	nificant conditions	contributing to d	leath but not re	esulting in the u	nderlying cause g	given in Part I.	1			he cause of death? ably 4 Unknown	
Records, P : The law requires t fricate has been sign f, page 2 should be c Completed t.		<u> </u>									opsy findings available	
e law i			-					peri	opsy formed?	death?	ompletion of cause of	
tal Recol	25. Was case refe	erred to medical		_		26.Place	of Death (Chec		2 No	1 Yes	s 2 No	
F Vital Physician: This certified director To Be	examiner? 1 ✓ Yes	2 No H	ospital: 1 Inp	atient 2	ER/Outpatient			sing Home 5	Residence 6	Other:	Scene	
of After t	27. Manner of De	ath	28a. Date of	Injury ay,Year)	28b. Time of Ir	njury 28c. Injur	ry at Work?		how injury occi			
sion Attendi death. ctur: y the f	1 Natural 2 Accident	5 Pending Investigation	on Aug 31, 20	012	FOUND: 1630 hrs		res 2 ✔ No					
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the tours after death. neral Directur: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P	3 Suicide 4 Homicide	6 Could not to	e l	of Injury - At ho Mobile Hon		t, factory, office b	uilding, etc.	or Town,			al Route Number, City	
Q E E E E	29a. Certifier (Check only	CertifyIng Physici	an: To the best o	of my knowledg	e, death occur			nd due to the car	use(s) and manr	ner as state	d.	
To the Ho within 24 To the Fu completel	one) 2		On the basis of and manner stat	examination ar ed	nd/or investigat			d at the time, dat				
> / ²	29b. Signature ar	d title of certifier				29c. License					th, Day, Year)	
(pV	30 Name and ad-	dress of person who d	ompieler	Ol death (Item	23a)	0.0.1	···		Septemb	1, 201	4	
OCME	Mary G. R	12	outy Chief Me		,	W. Baltimore	Street, Bal	timore, MD 2	1223			
State Registrar		nth, Day, Year)	82. Regi	strar's Signatu	backs	1						
DHMH 17 Rev 1/2001	36	F V 0 CVIC.	(Assert	70.	ORIGINAL				<u>. </u>			
OCEAR 2000												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harmone's Smith 21:24 M 08 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Baihmore University If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) 885-92-7698 **Director** 1 □ M 2 🂢 F 0 Yrs. 15 08/14/2012 Maryland "natural", or items 23a or 28a-f shov dical Examiner must be notified at 0a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Maryland Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1641 Gwynns Falls Parkway 21217 U.S.A. death 1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) မ Barbara C. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Jéánette Smith 1641 Gwynns Falls Parkway Baltimore, Maryland 21217 Grandmother 20a. Method of Disposition 20b. Place of Disposition (Name of Cremeter) crematory or other place) 20c. Location - City or Town, State Page 1 Date 1 Burial 2 XCremation 3 Removal from State 09/06/2012 Hanover, Maryland 4 Donation 5 Other (Specify) Center of Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. mar 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ ulmonary disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Pulmonary Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 <Physician/Medical the as nding | IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery the past 12 months?

Yes 2 No Ectopic pregnancy Month Pregnant at time of death Day Year 1 Yes 2 Unknown ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 performed? 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) Accident 1 🗌 Yes Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) D74703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcela Merchan Street Baltimore rrene

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	of Maryland / Dep	artment of Heal	Ith and M			28436	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	unicate of Deal	ui I	Reg. 2. Date of Death	No.	3. Time of Death	
	Physicia Medic			s M. Singer			Month August	29, 2012	10:23am	
	Examin		4a. Facility Name (if not institution, give street and no		4b. City, Town, or Loca			4c. County of Death		
	Francis		3304 Shirley Lan 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		y Chase	8. Date of Birth		place (State or Foreign	
	Funeral Director		060-16-3634 1X M 2 □ F		Months Days Hor	urs Min.	(Month, Day, Yea	Year) Country)		
	d tow		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Lo	ncation		12/20/1		10d. Inside City Limits	
	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	Maryland Montgomery	100.010, 100.110.1		y Chase	2		1 ☐ Yes 2 🛣 No	
	a or 28	<u>i</u>	10e. Street and Number		10f. Zip Code	· .	10g.	. Citizen of What Cou	· ·	
	ith with ms 23 must	ner	3304 Shirley Lan			0815	aify You or No-	14. Race - Ameri	S.A.	
ဖွ	or ite	by Fi	Armed	0 No	Was Decedent of Hispani If Yes, specify Cuban, Me		Rican, etc.)	Black, White,	etc.	
003	ours aff tural", al Exa	ted	3 Wildowed 4 Divorced Year or	Dates. WW I I	1 ☐ Yes 2 💆 No Spo	ecify:			white	
2	72 ho in "inal Medica	Completed	15. Decedent's Education (Specify only highest grade complete	(Give	dent's Usual Occupation kind of work done during OO NOT use retired)	most of workir	ng	o. Kind of Business/Ir	·	
212	within giene. er tha t, the I		Elementary/Secondary (0-12) College	(1-4 or 5+)	. Associatio	n Presi	ident	Food Broke	ers	
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	to Cincot	18. ř	Mother's Name	(First, Middle, Maid	len Surname) Stromer		
<u> </u>	should be file and Mental I is marked o raumatic eve		19a, Informant's Name/Relationship (Type, Print)	re Singer	ng Address (Street and N	lumber or Rural			Code)	
Ž.	d 2 sh alth ar n 27 is er trau		Phyllis Singer - Spous	T T	Shirley Lan			•		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once,		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 Removal from		matory or other place)			c. Location - City or T	·	
<u>Hi</u>	it. Page 1 intment of intant: If it injury or o		4 Donation 5 Other (Specify) 21. Signature of Fundar Servicy Licensee	King Davi	d Mem. Grdn 2. Name and Address of F				ch, Virginia	
Ba	permit. Departn Importa any inju		21. Signature of run an service Licensee		800 New Ham					
	Thysician/		23a. Part 1. Enter the disease, or complications the shock, or heart fully a. List only one cause on Immediate Cause (final	each line.		ch as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death Months	
	Medical		disease or condition resulting in death)	ongestive Hear o (or as a consequence of):	it failure				3 MOVILINS	
	Examiner	Į.	Sequentially list conditions, b.	o (or as a consequence of):						
	ted I ansit	Examiner	Cause (Disease or injury	o (or as a consequence or).						
	execu an and irial-tra		that initiated events c. Due to the control of the	o (or as a consequence of):						
260	ate be	edica	d							
89	certific nding use as	M/u		outcome of pregnancy ye Birth 2 Fetal death 3	☐ Ectopic pregnancy			23d. Date of deli	very	
Box 68760	e death the atte	Physician/Medical		egnant at time of death 5	Other (specify)			Month	Day Year	
P.O.	hat the led by detac	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in	Part I.	23e. Did tobace	co use contribute to	the cause of death?	
l, Sp	quires 1 en sign ould be						1 🗆 Yes	2 🗶 No 3 🗆 Pro	obably 4 🗆 Unknown	
COL	aw rec as bee	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of	
Be	r: The icate h		25. Was case referred to medical		20.51	. D	performed	d? death? No 1 ☐ Yes	2 🗆 No	
/ita	rsiciar s certif	To Be	examiner?	☐ Inpatient 2 ☐ ER/Outpatie	Other:	Death (Check		e 6 🗆 Other (Specia	5/I	
of	ng Phy ter this ineral (27. Manner of Death 28a. Da	te of injury 28b. Time o			28d. Describe how in			
ion	tendir death. tor: Af the fu	Certificate:	2 Accident Investigation	A home for a	M 1 Tes		2011		- Davida Alembar	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ce of Injury - At home, farm, sti Iding, etc. (Specify)	reet, factory, office		281. Location (Street City or Town, St	t and Number or Rura tate)	ai Houte Number,	
_	Hospit 24 hour Funera tely fills	Medical	29a. Certifier 1 X Certifying Physician: To the (Check 2 Medical Examiner: On the l	pasis of examination and/or invest	stigation, in my opinion, de	eath occurred at	the time, date and p	lace, and due to the ca	ause(s) and manner stated.	
	o the	M	only one) 3 Certifying Nurse Practition 29b. Signature and title of certifier	er: To the best of my knowledge	e, death occurred at the time. 29c. License num			ause(s) and manner as Date signed (Month,		
	F S F 0		H (XI) 19N	W) 12	890 DC		ugust 30,		
	iorly		30. Name and address of person who completed ca				1-7 (4) 1 *		00017	
/	V		Jon Wisdman, M.D., 541	O Connecticut Registral's Signatura	Avenue, NW, S	oute 1	11, Washi	ngton, VC	20015	
	Sta Registr		31. Date sled (No. 1/h, Gay, Yar) 2	1 P. 19 au						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 29 Day 2012 ear Physician/ 1952 Maximo Soto Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** (Month, Day, Year) Hours 213-39-9093 **Director** 1 🗶 M 2 🗆 F Dec. 1923 Peru 27, 88 works 10c. City. Town or Location 10d. Inside City Limits 10b. County with the Maryland Examiner must be notified at Director 28a-f 1 ☐ Yes 2 No Montgomery Village MD Montgomery 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral Peru 20886 18223 Lost Knife Circle, #102 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. ō 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 Peruvian If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Specify: Hispanic "natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ana Sierra Espinoza Eucebio Soto Rojas 20879 and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1113 Southern Night Lane, Montgomery Village, MD Rigoberto Soto, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Peru, Chincheros, Page 1 Peru, crum Uranmarca Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State dementario de Uranmarca9/25/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Simple Tribute Funeral/Cremation e of June III Service 21. Sign Center, 1040 Rockville Pike, Rockville, MD 20852 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between acute myocardial Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2-hours Medical Due to (or as a consequenc of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn Yes 2 7 No ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗗 No 2 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Reg Registrar

AMOMS.

NAXIMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, b, perFH, G936, Z/12/2013, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1908 M September 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NES HOSPITAL BALTIMORE NIA If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year) Director 1 M 2 W 1919 Kenlei permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be nother treumatic event, the Medical Examiner must be nother treumatic. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 1 Yes 2 1 No altimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2121. anc 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ Mo Specify: Specify: lac 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print)
Vivian I. Jones-daughter 19b. Mailing Address (Street and Number of Rust Floure Number, City (Town State 72 ip Code) 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Fores OWINGS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Lice 22. Name and Address of Facility AU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on expelline. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 XOER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury **M**latural work? 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation thin 24 hours after deat the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature a d title of c rtifie 2012 30. Name and completed cause of death (Item 23a) (Type, Print) 9005 (MD. Month, Day, Je 31. Date filed Registrar's Signatur ar State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sintember Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner N 8 Date of Birth Month, Day, 1 Year If Under 24 Hrs.
Days Hours Min. Birthplace (State or Foreign Country) last birthday **Funeral** 1 № M 2 □ F Months 94 **Director** Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. Count 10c. City Town or Location Director r 28a-f sh notified Xes 2 No 1011 altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ems 23a or r must be r Funeral **brook** "natural", or items . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Baltimoré, Maryland 21215-0036 1 Yes 2 Wo Specify If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Mondawmin Baltimore Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dațe Burial 2 ☐ Cremation 3 ☐ Removal from State oodlawn 2017 4 ☐ Donation 5 ☐ Other (Specify) altimore 21. Signat le of Funeral Service Lio Name and Address of Facility swell Funeral Heights enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 107 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Other (specify) Pregnant at time of death been signed by the a should be detached it Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 After this certificate has director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 🗌 Yes Accident 2 🗌 No Investigation Director: completed filled in by the Suicide 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type 0)

2. Registrar's Signature

29d. Date signed (Month, Day, Year) 9/3/12

Please Type or Print in Black Indelible Jak. English All Copies Are Legible. amend, State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 5 Month Physician/ Year Arthur Thomas 1252 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Aques Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 244-52-5935 Months Days Hours Min. (Month, Day, Yo 5-28-1938 **X**□ M 2 □ F Director NC 74 Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examina must be not the any loure. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 22 S. Athol Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 X Yes

If Yes, Give

Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 SpecifiAfrican-American 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administration Child Service Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Oulbert Henry Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arcelia Greene/ Daughter 5516 April Journey Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Metro Crematory 9-6-2012 Baltimore, MD 21. Signature of Funeral Scruize Lice S 22. Name and Address of Facility Wylie Fineral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, o shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician obstructive Du/monm disease disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a nonsequence of r attending physician and I for use as the burial-transi Cause (Disease or injury that initiated events Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical THOM AS ARTHUL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day cate has been signed by the a page 2 should be detached Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Dehydration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🔲 Yes filled in by the funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examine?? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 7 0068107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229 Villarreal Alejandro, MD 900 South Coton Avenue 32. Regis ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Thompson Month 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PG Clinton Southern Maryland Hospital 8. Date of Birth f Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Hours 579–46–2490 Usual Residence of De 1**X**□ M 2 □ F 6/18/1936 76 Washington, DC 10d. Inside City Limits 10b Counts 10c. City, Town or Location Temple Hills PG 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 20748 3521 25th Place 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2x Married 1 Yes 2 No 1 ☐ Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Covernment Press Worker PhD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Iona Woodland Walter Allen Thompson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3521 25th Place; Temple Hills, Maryland 20748 Shirley Elizabeth Thompson - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland National Cemetery 09/10/2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Freeman Funeral Services re f Funeral Service License 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part . Inter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death STROKE disease or condition resulting in death) SIGNOIS BILERTICULIT

Ph, sician/ Medical Examiner

attending physician and

the

signed by

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Completed

Be

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Certificate:

Medical

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I

completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

Physician/ Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he contact the Medical Examiner must he contact.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No 1 Yes 2 L 9 Unknown

yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

Day

Year

COAGU W.PATHY

1 Tyes	2 🗆 No	3 Probably	4 Unknown
24a. Was an	24b.	Were autopsy fin	dings available

23d. Date of delivery

Month

25. Was case referred to medical examiner? 2 No 27. Manner of Death

1 Inpatient 2 28a. Date of injury (Month, Day, Year)

ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? 1 Yes 2 No

Other:

performed? Yes 2 No 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify

1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) bely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 ARMOIL PLISLITE

RALTIMONE

Registrar

31. Date filed (Month, Day, Year) **SEP 0 6 2012**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 28442 Donna Joy Tyce State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 21, 2012 **Medical Examiner** Donna Joy Tyce 1030 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8340 Silver Trumpet Court Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year I if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours Months Min. Director 213-90-1290 49 Country) unk 2 X F Yrs 12/7/1962 Usual Residence of Decedent IIIV 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia 1 Yes 2 X No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If them 27 is anarked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8340 Silver Trumpet Court 21046 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White etc. 1 Yes 2 X No White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: **全** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Nurse Medical Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be unk Lorna Tyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Auth Carolyn W. Bateman Agent 5525 Green Bridge Rd Dayton MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem permit. Page:
Department o
Important: 1 8/25/12 Glen Burnie MD Donation 5 Other Specify: 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllen PA 7090 Ridge Rd Physician Wedical 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and Death a Mixed drug Intoxication (Alprazolam, Cyclobenzaprine, Diltiazem) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause Due to for as a consequence of (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit sician/Medical physician a the burial - 1 AMENDED 23a, 27, 28a-f, per me, g931 9-10-12 sm **X** UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending jor use as the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been a ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No ✓ Yes 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Intentional ingestion of Director: d in by the f 1 Yes 2 X No hours after death. fd 8-21-12 fd10:19am 2 Accident medication

28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide 6 Could not be or Town, State) 8340 Silver Trumpet. Columbia, MD. within 24 hours at To the Funeral D determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 22, 2012 mL of 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) SEP 0 6 2012 2. Registrar's Signature State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4b per np 2931 9-7-12 vt Fem 4b per np g931 9-7-12 vt State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2012 1WP 4 Caro /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, Brade tipno Peath 4c. County of Death Examiner PARKWAY BALTIMORE CENIER 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-24-1924 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min NORTH CAROLINA 216-30-7964 78 Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "edical Evancines must be redified at Director 1 ☐Yes 2 ☐ No N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 MOORE AVE. 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☐ No Specify. 3 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than "I College (1-4or 5+) Elementary/Secondary (0-12) -12-HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last)UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be CARRIE KNIGHT ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. JILL WILLIAMS (DAUGHTER) 2503 MOORE AVE. BALTIMORE, MARYLAND 21234 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial □ Crema 3 Removal from State ARBUTUS MEMORIAL PARK: 8-31-2012 BALTIMORE, MARYLAND 4 Donation 5 Doher (Specify) D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, F.A. 21. Signature of Fu al Servi 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc , or heart failure. List only one cause on each line. Immediate Cause (Final hysician disease or condition resulting in death) /Medical ue to (or as a consequence Examiner monic Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transi and (or as a consequence of) Box 68760. nein Condition attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 □Yes 2 12No ģ Month Year Day 5 ☐ Other (specify) P.0. ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Wital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy The perform After this certificate 1 □Yes 2 -N 2 H10 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours arten co....

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 Locartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) 31. Date filed (Month, Day, Year. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jusepin 2017 reakmbe Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Kaltmor Baltmore Multi-Care tacht LSWICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Country) Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth 9. Birthplace (State or Foreig **Funeral** Dec 1, 1923 104-16-7292 88 1 XXM 2 □ F **Director** 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director MD N/A Baltimore 1 XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3435 KEswick Road 21211 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 XXYes 2 No
If Yes, Give 10 Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Year or Dates. 1944 1 ☐ Yes 2xxx No Specify: White 3 ☐ Widowed 4 XX Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore City Housing Electrician unknown Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Gischel (Personal Representative) 3437 Keswick Road Balto, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cemeterly 9/14/12 Garrison Forest, MD 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 21. Signature of Faneral Service Lens e 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 Yes 2 No certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: . Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer of the fu Natural Accident injury 5 Pending 1 Yes 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles Street Balkmore 6701 M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #19a Per FH g932 10/01/2012 JH

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28445 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year 8-27-1 Uddin Siraj 2:17 p/m Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring **Examiner** 4c. County of Death montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 8-23-1942 70 249-48-6642 **Director** 1 Ϊ M 2 🗆 F Yrs India Usual Residence of Decedent show 10a. State 10c, City, Town or Location 10d. Inside City Limits must be notified at Director Md. 28a-f Spring Montgomery Silver 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 20904 Usa 320 Greenspring Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 Ϊ No Specify: Asian 'natural", Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Product Sales Produce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Noor BiBi n and Mental H ပ Saeed Khan t. Page 1 and 2 should by the and 0 Health and Mer rant: If item 27 is mark 19a, Informant's Name/Relationship (Type, Print) Naeem Maeem Uddin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Greenspring La, Silver Spring, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ott cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State George Wash Cemet: 8/28/12 Adelphi, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 411Kennedy st, n. w. 21. Signature of Juneral Service Licensee 20011 Universal Mortuary Inc, Wash, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. | Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1' ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐XUnknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 X No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29d. Date signed (Month, Day, Year) D24348 08 27 2012 30. Name and address of person wh cause of death (Item 23a) (Type, Print) My Struen JW+terman 1500 Forest Glen Rd. silver spring, Md. 31. Date filed (Month, Day, Year) State SEP 0 6 201 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Angnit Clarice 8:30 AM 2 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** N/A 5. Social Security Number 8. Date of Birth 0 7 / 3 1 / 1 9 6 5 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√ F Months Days Hours Min. 215-86-7685 47 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 XYes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2735 Liberty Parkway 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify. 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education ed other than "natu event, the Medical (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator The Can 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Roy Via Mary Carmichael ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,<u>co</u> Department of Health ar Important: If item 27 is any injury or other trau once. Katina Via(sister) 9892 Decatur Rd., MD Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 8-31-12 on-site Crematory 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 30 Sephodis Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, $_{
m MD}^{
m PA}$ 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sensia /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) resulting in death) Last physician is the buria Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: asn 1 Live birth 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ funeral dir this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 Tyes 2 No Accident rector: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, by 4 Homicide City or Town, State) 24 hours 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

4

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pillo

SEP 0 6 2012

SLOH

31. Date filed (Month, Day, Year)

1407113616

August 24.

4940 Eastern Avenue, Baltimore, MD, 21224

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh 9931 9-21-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ WILBON 2012 6:20 DANNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES HOSPITAL PRINCE GEORGES HEVERLY 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Dav. Year) 194 30 8955 Director 1 □ M 2 **X** F 73 POTTSTOWN, PA 1939 JAN. 3. "natural", or items 23a or 28a-f show dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGES 1 X Yes 2 No COTTAGE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3714 *30722* PARKWOOD ST. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: ITALIAN Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE OWNER LAUNDROMAT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN DNKNOWN 19a. Informant's Name/Relationship (Type, Print) husband
Lee Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 PARKWOOD ST. COTTAGE CITY, MD 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State 9/7/2012 BRENTWOOD MD FT. LINCOLD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BLANCHI FUN ERAL SERVICE, LLC M Ø1257 UPSHUR ST. NW WASHINGTON, DC 2001 814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CARDIAC FATAI disease or condition resulting in death) ARRITHMIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performe 1 ☐ Yes 2 X No Yes 2 X 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name ss of person who completed cause of death (Item 23a) (Type, Print) M CHEVERLL 3001 HOSPIYAL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ worell. Month Vivian Aug 451 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) **Director** 223-48-9126 1 🗆 M 2 🔯 F 76 1-16-1936 VΑ 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-1 sho: traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4224 Bonner Road 21216 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🏹 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: African-America 3 ☐ Widowed 4 🂢 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Dietician Sinai Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of ပ္ Leonard Dennis Hattie Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 street of Health a tant: If item 27 is jury or other tra Ann Smith/Sister 7314 Prince George Rd., Pikesville, MD 21208 Baltimore, 20b. Place of Disposition (Name of cernetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of P
Important: If ite
any Injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9-4-2012 Baltimore. MD Signature of Funeral Service Lieensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular disease Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day signed by the a 1 Yes 2 9 Unknown 2 No 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No nospice ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Snerman Emmett v	1- For State Registrar	epartment of Health and Mental H Certificate of Death	Reg. No. 2012 2844
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Sherman Emmett Walden		2. Date of Death Month Day August 30, 2012 3. Time of Death 0958 hrs
	4a. Facility Name (if not institution, give street and number) 3033 Strawberry Point Lane	4b. City, Town, or Location of Death Middle River	4c. County of Death Baltimore County
Funeral Director	217-62-4088 17M 2 F	yrs. last birthday)	—
nd show any ice.	Maryland Baltimore	City, Town or Location	10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tiffed at once.	10e. Street and Number 2341 Vandermast Lane	10f. Zip Code 21221	10g. Citizen of What Country? U.S.A.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatte event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year	in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - American Indian, Black,
5-0036 red within 72 hours afti- stygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade complete: Elementary/Secondary (0-12) College (1-4 or 5+) 11		work done 16b. Kind of Business/Industry red)
MD 21215-0036 1.2 should be filed within 7 th and Mental Hygiene. 1.27 is marked other than umatte event, the Medical To Be Comple	John Clarence Walden	18.Mother's Name Esthe	
ID 21 2 should and Me 27 is ma matic ev	19a. Informant's Name/Relationship (Type, Print) Carol Barber (Daughter)	*	Rural Route Number, City or Town, State, Zip Code)
lore, N ges I and 2 tt of Health :: If item 2	20a. Method of Disposition 2 1 Burial 2 X Cremation 3 Removal from State	Ob. Place of Disposition (Name of cernetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If itee	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22 Name and Address of Facility	31/2012 Baltimore, Maryland i Funeral Home, P.A. Avenue, Essex, Maryland 21221
Physician Medical Examiner	Part I. Enter-the disease, or complications that caused the defailure. List only one cause on each line. Immediate Cause (Final disease a. Drowning	eath. Do not enter the mode of dying, such as cardiac o	AVenue, Essex, Mary and 21221 r respiratory arrest, shock, or heart Reproximate Interval Between Onset and Death
	or gendition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence) b. Due to (or as a consequence)		
ted 1 unsit Examiner	cause. Enter Underlying Cause (Usaces or injury that initiated events resulting in death) Last Due to (or as a consequence d.		
: 68760, certificate be executed noting physician and use as the burial - transit ciant/Medical Exi	UNPENDED AMENDED		
certificanding plans as the	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of past 12 months? 1	2 Fetal death 3 Ectopic pregna	23d. Date of delivery ncy Month Day Year
- 8 90 e _	Part II. Other significant conditions contributing to death but n	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ✔ No 3 ☐ Probably 4 ☐ Unknown
of Vital Records, P.O. Box **Residual Properties that the death of the state of the configuration of the state of the configuration of the state of the configuration, page 2 should be detached for unit To Be Completed by Physic of the Physics of the properties of the configuration			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
/ital /sician is certi director	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	26.Place of Death (Check of Berloutpatient 3 DOA Other Nursin	only one) g Home 5 Residence 6 ✔ Other: Scene
ㄷ뤼글飞리 히	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Aug 28, 2012	28b. Time of Injury 28c. Injury at Work? 1558 hrs 1 Yes 2 № No	accidental drowning in the Middle River
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune- edical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) water of Middle River, Middle River, MD
To the Hos within 24 h To the Fur completely		vledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	
D. J.M.	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 31, 2012
NA.	30. Name and address of person who completed cause of death (i Pameta E. Southall, MD Assistant Medical E		nore, MD 21223
State Registrar		lature A	

12-06585	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.														
Charlene Ann W		1- For State Registrar	tate of Maryl	and / I	•	ment of icate of			J Mental H		Reg. No.	201	2 2845		
Physicia Medical Examir		1. Decedent's Name (First, Midd Charlene Ann Wo								2. Date of De Month August 3		Year	3. Time of Death 1830 hrs		
		4a. Facility Name (if not institution 1468 Stoney Point W	on, give street and n	umber)		4	b. City, T		Location of Death	h	40	c. County of Deatl Anne Arundel			
Funeral		5. Social Security Number	6. Sex	7. Age ((In yrs. last bi	pirthday)		er 1 Year		s. 8. Date of		I/DD/YYYY) 9. Bir	rthplace (State or		
Director		224-68-1657	1M _2_XF		63	Yrs.	Month	s Days	Hours Mir	10/07	/194	Forei	_{puntry} Virginia		
any	ł	Usual Residence of Decedent 10a. State 10b. County		10	0c. City, Tow	vn or Locatio	 on						10d. Inside City Limits		
yland -f shnw	호	Maryland Anne 10e. Street and Number	Arundel_	\bot	Curt	is Bay	У 10f, Zip	Codo			I 10a Cit	tizen of What Cou	1 Yes 2 No		
the Mar	Director	1468 Stoney Pos	int Wav				TOI, ZIP	2122	26		log. Citi	U.S.			
th with t	- L	11. Marital Status 1 Never Married 2 M	12. Was De	orces?				nt of Hisp	panic Origin? (S , Mexican, Puerto		rican Indian, Black,				
fter deal			1 Yes		No.			X No				Specify: Whi	ite		
hours a	ed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		as: Lest grade completed) 16a. Decedent's Usual Occupation (Give kind of word during most of working life. DO NOT use retired							ork done 16b. Kind of Business/Industry				
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15-0 filed w al Hygie ed othe											e, Maiden	Surname)			
212 nould be id Menta is marko	2	19a. Informant's Name/Relations	ship (Type, Print)			lumber, C	Rebecca	e, Zip Code)							
, MD and 2 sho ealth and tem 27 is traumati		Steve O'Hearn 20a. Method of Disposition	(Son)			2936 N e of Disposit				oodbrid Date		irginia Location - City or			
MOFE, Pages I an nent of He ant: If ite		1 X Burial 2 Cremation 4 Donation 5 Other S	_	rom State	crema	atory or other	er place)		Cem 09/			•	, Virginia		
Baltin permit. P Departme Importa injury or	f	21. Signature of Funeral Service		00-73									MD 21225		
Physician	\dashv	23a. Bart I. Enter the disease, or		caused the	e death. Do r	not enter the	7 Ľa e mode c	<u>śt Pa</u> fdying, s	atapsco such as cardiac (Avenue or respiratory a	: Ba⊥ arrest, sho	ck, or heart	Approximate Interval		
/Medical Examiner		failure. List only one cause	_{e a.} Atheroscle			ular Dise	ase						Between Onset and Death		
ie į		or condition resulting in death) Sequentially list conditions,	Due to (or as a	a consequ	uence of):										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause													
ecuted and - transit	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequ	uence of):								·		
	edical	UNPENDED	AMENDED						77						
ox 68760, anth certificate be ex attending physician for use as the burial	n/Me	IF FEMALE: 23b, Was decedent pregnant in the			of pregnancy		al death	3	Ectopic pregna	ancv	230	d. Date of deliver	y Day Year		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/M	past 12 months? 1 Yes 2 No 9 Uni		nant at tim	me of death		er (Spec								
O. Be at the de de by the stached for		Part II. Other significant condit			out not resulti	ing in the ur	nderlying	cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the Is after death. To Director: After this certificate has been signed by I led in by the funeral director, page 2 should be detached.	ted by	Dehydration	-							1 Y			bably 4 Unknown utopsy findings available		
cords, law require, has been s	Completed									aut per	topsy rform <u>ed</u> ?	prior to death?	completion of cause of		
tal Rection The certificate ector, page	a	25. Was case referred to medica	al					6. Place	of Death (Check		s 2 ✓ N	No 1 Ye	es 2 No		
Physician rathis of	e P	examiner? 1 Yes 2 No 27, Manner of Death	Hospital: 1	Inpatient		Outpatient		···	Other Nursir	ng Home 5		ence 6 🗸 Othe	r: Scene		
ion of tending Pheath.	Certification:	1 ✓ Natural 5 Pend	(Monti	h, Day,Year)	r) 200.	i. Time of inj	jury		es 2 No	28d. Describ	e now inju	ury occurred			
livisior I or Attence after death Director: d in by the	tifica	3 Suicide 6 Coul	ild not be		y - At home,	farm, street	, factory,	office bu	uilding, etc.	28f. Location or Town,		and Number or Ru	ural Route Number, City		
Divi		4 Homicide	Physician: To the be		nowledge, de	leath occum	ed at the	time, dat	te and place, and	d due to the ca	ause(s) ar	nd manner as stat	ed.		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	힜	one) 2 Medical Exa	aminer: On the basis and manner:	of examin	_		on, in my	opinion,	death occurred a		ite and pla	ace, and due to th	ne cause(s)		
	2	29b. Signature and title of certifie	1119				290	O.C.M				Date signed <i>(M</i> o ptember 4, 20			
AD/	-	30. Name and address of person	· ·			-	Щ								
JW	327	Laron Locke MD. A 31. Date filed (Month, Day, Year)	Assistant Medica		Signature	0 W. Bal	timore	Street,	, Baltimore, I	MD 21223					
Regist		SEP 0 6 2015		. 1	ba	wer									

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene											
			Registrar	Cer	tificate of L	Death		Reg. No. 20	12	28451		
	Physicia		1. Decedent's Name (First, Middle, Last) Charles Edward Wenzel, Jr.				2. Date of De Month	Dav	Year 112	3. Time of Death		
and the same	Medic Examir		4a. Facility Name (if not institution, give street and number)		4h City Town or	Location of Death	Aug.	4c. County		7 7		
-1			Power Back Rehabilitation		Timo				ltimo	re		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th		lace (State or Foreign		
	Director		218-22-1547 1∑M 2□F 83	Yrs.	Months Days	Hours Min.	(Month, Da		Count			
	ld bow tt] _	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Loc	L		sept./	1920				
	ırylan a-f sh ied a	Director	100.0						1	0d. Inside City Limits		
	r 28g		MD Baltimore T:	imonium	10f. Zip Code					1 Yes 2 No		
	/ith th							10g. Citizen of V	Vhat Coun	try?		
	ath v	Funeral	12246 Roundwood Rd., #107	S 13 V	21093	ispanic Origin? (Spe	cify Yes or No-	USA	A t			
9	or its		Armed Forces?		Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		e - America k, White, e			
03	ırs aft ıral", Exal	Completed by	1 ☐ Never Married 2 ☐ No If Yes, Give 2 ☐ No If Yes, Give Year or Dates. ! 46—!	48	☐ Yes 2X No	Specify:		Specify:	W	hite		
5-0	"natu	Bet Bet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	ation during most of worki	200	16b. Kind of Bu	siness/Inc	dustry		
121	hin 77 ne. Ithan e Me	E O	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DC	O NOT use retired)	ding most of work	ng					
2	d with	BeC	12 5+	Teach	er			Educa				
anc	ntal Fred o	To E	17. Father's Name (First, Middle, Last) Charles Edward Wenzel, Sr.			18. Mother's Name		Maiden Surname)			
Ĕ	ould by mark		19a. Informant's Name/Relationship (Type, Print)	T		Mary He						
Maryland 21215-0036	2 shouth and the street of the		Claire D. Wenzel/wife			and Number or Rura						
ē,	Hea Hea Item			Place of Dispos		vood Rd.,	_#1U/,	20c. Location -				
m0	ent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify)entombment Du	cemetery, crem	atory or other plac	e)				,		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euleral Service Licensee	Laney 22	Name and Addres	s of Facility	9/3/12	limoni	um,	MD 21093		
m	Depar Impo any ir		Michael Plagle	l e	mmon Fune 0 W. Pado	s of Facility eral Home onia Rd.,	of Dul Timoni	aney Val um, MD 2	1ey3	Inc.		
			23a. Cart 1 Enfer the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arr	rest,		Approximate		
en.	Physician/		Immediate Cause (Final	LANGE AL	Λ				17	Interval Between Onset and Death		
1	Medical Examiner		resulting in death) a. Due to (or as consequence)	uence of):						IVECHS		
	LAGITIMIO	er			RAL EFF	ISIONS						
. 4	ed isit	min	if any, leading to immediate Due to (or as a consequence. Enter Underlying Cause (Disease or injury	uence of):								
18	ecut	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence)	uence of):					-+			
0	eate be executed physician and the burial-transit	dical Examin										
376	ficate g phy as the		_ u			-						
39	endin use	an/N	IF FEMALE: 23c. If yes, outcome of pregnat 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fet	ancy	Ectopic pregnance			23d. Date	e of delive	ry		
BO	death	sicia	1 Yes 2 No 4 Pregnant at time of	death 5	Other (specify)	у		Mor	nth	Day Year		
o O	t the	Physician/Me	a Cliviowii									
σ.	ss tha igned be de	by	Part II. Other significant conditions contributing to death but not res	sulting in the ur	iderlying cause giv	en in Part I.		_		e cause of death?		
rds	een s een s	ed					1 🗆 `	Yes 2 No	3 ∐ Prob	ably 4 🗆 Unknown		
000	law n has b e 2 sl	Completed					24a. Was a autop	sy p	rior to con	sy findings available apletion of cause of		
æ	: The cate r, pag						1 \(\text{Yes}		eath?	2 🗆 No		
ital	sician certif recto	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		26. Pla	ice of Death (Check						
<u>></u>	Phys r this aral di	5: 10	1 Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of	28c. Injury	4 Nursing Hor						
n o	nding th. : After e fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work?	Yes 2 No	escribe n	ow injury occurre	a			
Sic	Atter	Ħ	3 Suicide 6 Could not be 28e. Place of Injury - At ho	me, farm, stre			28f. Location (S	treet and Number	r or Rural I	Route Number.		
<u>.</u>	al Dire		building, etc. (Specify)			City or Tow					
	lospit 4 hour unera ely fill	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	ledge, death or	ccurred at the time	, date and place, an	d due to the ca	use(s) and manne	er as state	d.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	≥	only one) 3 L Certifying Nurs Practitioner: To the best of r	ny knowledge,	death occurred at th	e time, date and place	ce, and due to the	ne cause(s) and ma	anner as st	ated.		
	5 ≥ S S		29b. Signature and title of certifier		29c. License		1	29d. Date signed				
	140		My Sala Mi			58656		09/0	4/2	2012		
	dri		30. Name and address of person who completed cause of death (Item Dr. Mark Saba 7505 Osle		,	205 Torre	on MD	21204				
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signa		-, Durte	LUUS TUWE	TID CITO	<u> </u>				
	Registra		SEP 0 6 2012 Some S.									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN REAVES WATERS September 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death 3604 Vellabrooke Street Olneu Montaomeru 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Months Hours Min 218-34-5727 Director 1 X M 2 🗆 F Yrs 74 Jan. 3. 1938 Washington, DC show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? ms 23a or must be Completed by Funeral 3604 Dellabrooke Street 20832 United States ral", or items 2 Examiner mus and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. "natural", 3 Divorced 4 Divorced Specify: White artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Food Store Assistant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Waters Ruby Gannis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Dellabrooke Street, Olney, MD 20832 Marlene A. Waters. 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State Brentwood, MD 4 Donation 5 Other (Specify Lincoln Crematory 9/10/2012 21. Signa ure of Funeral sorvice 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disea shock, or heart failure ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, I. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Examir the burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Multiple Myeloma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Mitral Valve Regurgitation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. within 24 hours ar er dearh.

To the Funeral Director: Af completely filled in by the fu Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar 1396 Piccard Drive.

Name and andress of person who completed cause of death (Item 23a) (Type, Print)

M.D

Joel Kalman,

29c. License number

D20367

Rockville, MD 20852

29d. Date signed (Month, Day, Year) September 4, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Eugene Weddington 2. Date of Death 3. Time of Death Physician/ 1:05 P. M Medical 4a. Facility Name (if not institution, give at eet and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Raven Baltinion N A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days (Month, Day, Country) 92 -043 Yrs. Director May 1920 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MI Hmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Kaven 21239 10101 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?
1 2 Yes 2 □ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Blac 3 ₩idowed 4 ☐ Divorced Specify: If Yes, Give Year or Dates. Army Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Meta Be 17 Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Weddington t and 2 should by the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONC or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Injury (4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur uneral Service Licensee 22. Name and Address of Facility any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Baeterem, a Onset and Death Pnysician/ Known Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed ng physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FFMALE nse If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò 5 Other (specify) Month Day Year been signed by the s Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has page 2 s autopsy performed certificate 1 🗌 Yes 2 🗆 No 2 N Division of Vital the Hospital or Attending Physician; the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27, Manger of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 34354 (OHIO) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Lah m.D. Boulevard Bultimore maryland 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month YOLKEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death xed of th N/AHowie t mass If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 1 ፟M 2 □ F 262-68-4663 69 03/07/1943 Usual Residence of Decedent MD th and Mental Hygiene. 27 is marked other then "natural", or items 23e or 28e-f show traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3000 STONE CLIFF DRIVE, #301 21209 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ğ 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SALES MENS ACCESSORIES Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pege 1 end 2 should be filr ment of Health and Mental ည ROBERT YOLKEN LORRAINE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE YOLKEN/WIFE 3000 STONE CLIFF DRIVE, #301, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ò Important: i any injury o 4 ☐ Donation 5 ☐ Other (Specify) 09/05/2012 BETH JACOB CONG. FINKSBURG, MD Signature of Juneral Service I 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 60×10 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2011 atori Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertensin 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Atticel Sibiliat 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 2 🗌 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) -Registrar

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ Month 1:23 A Reggie J. Ashley August 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Chestertown Chestertown Nursing & Rehab. Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 244-40-3023 84 1 XM 2 □ F North Carolina 8/1/1928 Usual Residence of Decede ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 TyNo Chestertown Maryland Kent 10e. Street and Number 10g. Citizen of What Country? United States Funeral 21620 415 Morgnec Road 12. Was Decedent Ever in U.S. Armed Forcest? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo Specify: 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 is fleath and Mental Hyglene.
If Item 27 is marked other than "re or other traumetic event, It is Men Elementary/Secondary (0-12) College (1-4 or 5+) Arborist Tree Surgeon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Roten Charles Ashley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $227\frac{1}{2}$ High Street, Chestertown, Maryland 21620 Douglas J. Ashley/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 a
Department of I
Important: If ite
any injury or ot Page 1 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/20/2012 | Annapolis, Maryland Hillcrest Memorial Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Fyn Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Recalcitrant Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Diastolic Dysfunction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of doots 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 1 ∐ Yes 2 L 9 ☐ Unknown □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Type II Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 8 1 Tes Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signate re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/17/12 D23889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 06-2011

State Registrar Jr.,

John C. Arraba1, 31. Date filed (Month, Day, Year) AUG 20 2012 M.D.

223 High Street, Chestertown, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 1217 Рм August Christine Alvanitakis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ceci1 Elkton Care and Rehabilitation E1kton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month Day, Year) ay 17, 1929 1 □ M 2 🗓 F Days Hours Months Director <u>168-24-6039</u> May Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 116 West Thomson Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 🟋 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Records Supervisor County Prison System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of ည Thomas Christopoulos Paraskevi Dokos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau once. Annette Vanaskey/Daughter 121 Park Towne Drive, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State August Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Chester Rural Cemetery 2012 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROYASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CEMEBINAL INFAME WEEKS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed PHEUMOHIA 1 WEEK that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical 4 WERKS ALZITKI MKILS DEMENTIA Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 X No ed by the a 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SEC. TO CLOSTUDIUM DIFFICILL 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page After this certificate 1 Yes 2 No Yes Be 25. Was case referred to medica director, 26. Place of Death (Check only one) Hospital 2 🔀 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury s after death.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

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Registrar
DHMH 17 Rev 7/2009

State

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A-NAJERA, M

ROLANDO

31. Date filed (Month, Day, Year)

SEP 0 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. D.

32. Registrar's Signature

DO07463

ELLUTON CHIEF FREHAR, IPPLIEDR. ELLUTON, MD. FIGS

8-73-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ August 17 ay 2012 11:55 A.M Elizabeth Parker Burrows Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 5111 Valley Pine Ct. Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) (Month. Dav. Year Davs Hours 032-24-0568 81 Director 1 🗆 M 2 🗓 F 11/05/1930 Pennsylvania Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at 10b. County 10c. City, Town or Location Director item 27 is marked other than "natural", or items 23a or 28a-f so other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21703 5111 Valley Pine Ct. should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elizabeth Lockwood William Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Burrows/ spouse . Page 1 and 2 sl tment of Health a 5111 Valley Pine Ct., Frederick, MD 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of I Important: If its any injury or of 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Stauffer Crematory 8/20/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licensee Jacque th 1621 Opossumtown Pike, Frederick, MD 21702 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between set and Death Immediate Cause (Final MOCARDIAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Orany if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Pregnant at time of death been signed by the a should be detached Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy perforn death? 1 Yes 2 No after death.

Director: After this certificate | 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 🗌 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Mghth, Day, Year) 29c. License number Celon JULINO he completed cause of death (Item 23a) (Type, Print) NCharles Street Battimore, MD 30. Name and address of perso DILL MD 0

Registrar
DHMH 17 Rev 06-2011

State

Day, Year

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gistrar's Signature

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 ☐ Burial 2√	osition Cremation 3 5 Other (Spec	Removal from	State	-	crematory	or other place	· ·		st 15,	1		•	own, State	
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Division of Vital Records, P.O. Box 68760 ral or Attending Physician: The law requires that the death certificate be earlineath. In interior. After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the buring the funeral director.	Physician/Medica	IF FEMALE:			= 71											
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	ĕ ⊠	only one) 3	Certifying Nu	rse Practioner:	To the best of	of my knowled	dge, death	occurred at th	ne time, da	ate and plac	ce, and due to	the cause	e(s) and ma	anner as s	ated.	
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Je Ko		30. Name and addre	ess of person who	completed cau	se of death (Item 23a) (Tv	pe, Print)		00	36	> 8	/\	3	1	1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28459 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 6 Day 2012 ear 1910 Maddie Barrer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Rockville Shady Grove Adventist HOspital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 6, 2012 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖳 038-50-9269 Mary Tand **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? 20904 67 Eldrid Dr USA. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. þ 1- Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Barrer Amy Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 67 Eldrid Drive Silver Spring, MD 20904 Amy Barrer - Mother permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan Crem. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 8-19-12 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Servie Licensee 22. Name and Address of Facility Metropolitan FS 5517 Vine St Alexandria, VA 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death xtreme crematurit Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner of membranes vennture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No 2 N 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 🗌 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 58033 CA

State Registrar

267

6,000

Medical center Drive, Suite 330,

Rockville, Momland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715

82. Registrar's Signature

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31. Date filed (Month, D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#18 per FH State of Maryla 8/23/2012 AACOHEALTH DEPT. CMH Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c **Examiner** Arun 8. Date of Birth (Month, Day, Year) P Age (In yrs. last birthday I Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 👿 87 219-12-3317 Louisiana **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Anne Arundel Crownsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1011 Waterbury Heights Drive 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) US Naval Academy Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) မ Poblet Marie Joseph Bergez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7782 Edgewood Road, Pasadena, Maryland 21122 Tricia Withrow/Grandchild Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 8-19-2012 Edgewater, Maryland 4 Donation 5 Other (Specify 21. Signature Funer 22. Name and Address of Facility George P. Kalas Funeral Home Edgewater, MD 21037 2973 Solomons Island Rd., Part 1. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Interval Between
Onset and Death shock or heart failu Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 🗌 Yes 2 🗌 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ANO မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Mon

AUG 20

Name and address of person who completed cause of death (Item 23a) (Type, Print

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eckerle Kenneth 14, :30 p. 2012 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Center Citizens Care and Rehabilation Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) Hours Min 309-38-8779 **Director** 1 🖁 M 2 🗆 F 75 Usual Residence of Decedent 18. 1936 Indiana or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick 1X Yes 2 □ No Monrovia 10e. Street and Number ms 23a or must be r 9 10f. Zip Code 10g. Citizen of What Country? Funeral 3901 Maurice Court 21770 USA items within 72 hours after death Was Decedent Ever in U.S. Armed Forces ↑
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. the Medical Examiner Black, White, etc. ō <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 'natural", White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Physicist NIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fish marked of ၉ Alphonse Eckerle Thresia Marks traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i David Ruppert / Friend 11228 Waycross Way, Kensington, MD 20895 other 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 4 ☐ Donation 5 ☐ Other (Specify) 8/18/2012 Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Pheimonia Medical Due to (or as a consequence of) Examiner aveinson 5 Disease Sequentially list conditions, if any leading to improve cause. Enter Underlying Cause (Disease or injury Examine burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Por 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by An emia 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Hospital or Attending Physician: The this certificate 1 🗌 Yes 2 🔲 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pendina death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A

Completely filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number D60417 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Redistrar's Signature

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State of Maryland / Department of Health and Mental Hygien	ne o l o	

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" Undun	Attendent deat ector; by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could determ	not be 28e. Place	of Injury - At ho	me, farm,			res 2 L	_ NO	28f. Location			er or Rura	al Route Num	ber,
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	To the To the comp		29b. Signature and			11-			c. License	number						Pay, Year)	
			30. Name and add	resport	Who completed baus	e of death (Item	2301/5	()	16	428				01	14	12	
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53	Sta Registr		31. Date filed (Mon	th, Day, Year) AUG 2	32. R	gistrar's Signat	ture _	backs									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin Inpatient Care Center Social Security Number 9. Birthplace (State or Foreign Country California If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 6 Sex 7. Age (In yrs. last birthday) Days Hours 406-88-9240 56 Director 1 □ M 2 🖫 F Feb. 18,1956 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show anose. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 ☐ Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 12 Evergreen Trail 12. Was Decedent Ever in U.S. Armed Forces? 1978.

1 X Yes 2 No 1984 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 🗌 Widowed 4 🗌 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Home** Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maria Guertta Nicholas A. Andreacchio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 Jeffrey Lawes Gwilliam/Husband 12 Evergreen Trail 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State August 15, 2012 1 Burial 2 Cremation 3 Removal from State Metro Crematory, INC. 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licer 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ESPIRATORY AIWRE TCUTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MONTHS TROPHIC Myo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ieral urector: After this certificate has been signer filled in by the funeral director, page 2 should be a 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) gnature and title of of tific Q 10x Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

AUG 16 2012

ENTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28465 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8 mor 5 PM Medical Facility Name (if nat institution, give street and num Examiner 4b. City, Town, or Location of Death County of Death Polis enter 8. Date of Birth (Month, Day Year) If Under 1 Year If Under 24 Hrs **Funeral** Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign (Popuntry) M 2 □ F Hours Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dide 1 Yes 2 No hade 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ona 41 more 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numb -, ity or Town, 3 man 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specific 20b. Place of Disposition (Name of Date BESTGATE MEMORIAL 8/13/2012 ANNAPOLIS, MD 21. Signature of Funeral Service License NEWNA ROAD, BESTGATE ANNAPOLIS, art 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Phy i i n disease or condition resulting in death) mi Medical Due to (or as a.co) Examiner Imin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to ras a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🔲 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Other: မြ within 24 hours after deaun.

To the Funeral Director, After this commieted filled in by the funeral dir Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oli 1 edical

Registrar
DHMH 17 Rev 7/2009

State

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kathy Diane Hewitt State of Maryland / Department of Health and Mental Hygiene 1- For State 2012 28466 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** Kathy Diane Hewitt 0348 hrs August 18, 2012 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours 219-66-2760 56 1_M 2XF 08/11/1956 Country) Usual Residence of Decedent iny 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits MD Frederick 1 Yes 2 X No Thurmont Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6508 F Mountaindale Road 21788 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White, etc. 2 Married 2 X No Yes f Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify: White ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laundry Tech Charles River Labs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Clifford Hewitt Stella Gravley ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Nunemaker / mother 5 Weil Dr., Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, Burial 2 X Cremation 3 Removal from State Stauffer Crematory 8/23/2012 Frederick, MD Donation 5 Other Specify 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 104 E. Main St., Thurmont, MD 21788 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Exsanguination Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Bleeding Duodenal Ulcer Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed and Physician/Medical g physician a UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending por use as th 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✓ No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 줕 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Division 1 🗸 Natural 5 Pending 1 Yes 2 No the 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours at To the Fuoeral D determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 18, 2012 rounel 30. Name and address of person who completed cause of death (Item 23a) 0 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	position			Place of Dispo	sition (Name of natory or other pla	:		Date	20c. Location		own, State	
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Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death												
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Attending I er death. ector: After by the funer	Certificate:	1 Natural 2 Accident	5 Pending Investigati	on (Monti	n, Day, Year)	injury	WO		_	20d. Describe in	ow injury occur	led		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 12 ay 2012 a 10:40 A M Hiers Marna K. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14202 Adkins Road Laurel Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 196-18-0567 1 M 2 X F 88 PA October 9,1923 ral", or items 23a or 28a-f show Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Prince Georges 1 X Yes 2 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14202 Adkins Road 20708 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 X No If Yes, Give "natural", or 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates the Madical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Cyrus Housel Berdella Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Hiers/ Daughter Page 1 and 2 14202 Adkins Road Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place)
Huntt Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 8/15/2012 Waldorf, MD 22. Name and Address of Facility Fleck Funeral Home 21. Signature of Femeral Service-Li 7601 Sandy Spring Road Laurel, MD 20701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Day detached 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANPBC **AUG 16 2012** Registrar

State of Maryland / Department of Health and Mental Hygiene 2012 28469 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Law Hartge August 17^{Day} 2012 11:25 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4890 Anchors Way **Galesville** Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min (Month, Day, Year) **Director** 217-16-8932 1 X M 2 □ F 89 Yrs Oct. 13, 1922 Maryland Usual Residence of Decedent or 28a-f show 10c. City, Town or Location be notified at 10d. Inside City Limits Director MD Anne Arundel Galesville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a event, the Medical Examiner must 4890 Anchors Way 20765 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates. WWII Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Marine Architect Navel Engineering 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oscar Hartge Alice Wayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Hartge (spouse) 4890 Anchors Way Galesville, MD 20765 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quaker Cemetery 8/21/2012 Galesville, MD 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Hardesty Funeral Home 7 905 Galesville Rd. Galesville, MD 20765 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Artera disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy ō Day Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🗆 Hatural 5 Pending injury within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 2112 D5 1319 10% completed cause of death (Item 23a) (Type, Print) 241 Halida 132 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HANNIGAN ELLEN BARBARA Medical 2012 25P AUGUST 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Days (Month, Day, Yea uly 9, 1 89 Months Hours Min. Country) 195-18-0928 Director 1 - M 2 - F Pennsylvania July or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Frederick Maryland Frederick XX Yes 2 \ No 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21701 Funeral 410 Burck Street 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married 2 🗌 No filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: IT Yes, Give Year or Dates. 1944-1945 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Office Work/Admission Hospital other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret McCahill 17. Father's Name (First, Middle, Last) Thomas Joseph Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 Providence Circle, Walkersville, MD 21793 James G. Hannigan III, son Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory Aug. 28, 2012 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service 22. Name and Address of Facility. Keeney and Bastord PA Funeral Home M00255 East Church St., Frederick. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial /Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 Mo g 🗌 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be dev 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate dnen 2 No 1 Yes 25. Was case referred to ica Yes 24 No funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 D ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: After t 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 U matural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who come 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 6 201 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 25,27,28a-f, per me, g931 9-18-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22.001M MARY ELIZABETH JEWELL AUGUST 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death EASTON TALBOT HOSPITAL MEMORIAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 213-24-0095 Director 1 □ M 2 X F Yrs 84 06/10/1928 MARYLAND Usual Residence of Decede and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show
is marked other than "natural", or items 23a or 28a-f show
raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🌠 No MD QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 CASTLE MARINA ROAD 21619 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) NURSING ASSISTANT HEALTH CARE Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be SELBY SKINNER ESTHER HADDAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau CHARLES JEWELL / SON 5128 MAIN STREET. GRASONVILLE. MD 21638 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 08/25/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EPIDURAL HEMATOMA WITH MASS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of sician and burial-transit Exami NER CERTIFICATION APPROVED Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? ≦ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: me within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes 2 TING 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) စ္ 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 🛣 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending iniury 2 🕱 Accident
3 🗌 Suicide
4 🗍 Homicide subject fell fd 8-17-12 Investigation fd 1:00A^M 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 205 Armstrong St. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Assited Living Facility Centreville,MD. Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD KROWNEN 0066441 AUGUST 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton 21601 Ramesh Stream MD Kolli 2195 washington 31. Date filed (Month, Day, Year) AUG 2 1 2012 32. Registrar's Signature State Registrar

4

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8/13/2012 TED ANTHONY JARVAIS 2:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7034 HARBOR VILLAGE COURT APT. T1 ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 346-54-5895 Director 1 X M 2 □ F 51 2/16/1961 WISCONSON Usual Residence of Dec or 28a-f show notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral within 72 hours after death with must |7034 HARBOR VILLAGE COURT APT T1 21403 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1 No If Yes, Give Year or Dates. 1980 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed r than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other the the **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ROGER JARVAIS GLENDA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMELA JARVAIS/WIFE 7034 HARBOR VILLAGE COURT APT T1 ANNAPOLIS, MD 21403 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CROWNSYTLLE VETERANS CEMETERY 8/16/2012 CROWNSVILLE, MD 4 Donation 5 Other (Specify) Address of Facilit LASTING TRIBUTES BY FELLOWS BEIN & NEWNAM CREMATION & FUNERAL CARE Signature of Funeral Service any ir Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Claney Hospital or Attending Physician: The law requires that the death certificate be executed Cancer and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending injury n 24 hours after death. e Funeral Director: Aft etely filled in by the fur Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 069602 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) altimore, Mb, 21271 State Registrar

Amend #19b per AA Co. Health	Fu Dep	n Dir Please t 8/16/2012 lo	e Type or Print in B			-	_	
	L	For State Registrar	State of Maryland		e of Death		ene g. No. 2012	28473
		Decedent's Name (First, Middle, La	ast)	00/1///041	<i>5 01 15 000.</i>	2. Date of Death		3. Time of Death
Physici Med			hnson			August	Day Year	2 8-30 AM
Exami	ner	4a. Facility Name (if not institution, give Baltimore Was)			Town, or Location of Deat	ie	4c. County of Deat	Arondel
Funera Director		5. Social Security Number 6.	Sex			(Month, Day, Ye	9. Bir Co 2 1930 T	thplace (State or Foreign untry) /irginia
land show dat	to	10a. State 10b. County	10c. City,	Town or Location			<u> </u>	10d. Inside City Limits
1 G M 36 after death with the Maryland "", or items 23a or 28a-f sho kaminer must be notified at	Director	Maryland Anne	Arundel Mil	lersvill				1 X Yes 2 □ No
vith th	ral	982 Oakdale C	ircle		108	109	g. Citizen of What Co USA	ountry?
Seath views	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		lent of Hispanic Origin? (S Sify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame	
	ed by	1 ☐ Never Married 2 ☐ Married ※XX Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		2 ☑ No Specify:	,	Black, Whit	
21215-00 within 72 hours giene. er than "natura", the Medical E.	Completed	15. Decedent's (Specify only highest o		16a. Decedent's Usua (Give kind of wor life. DO NOT use	rk done during most of wo	rking 16	6b. Kind of Business	/Industry
d 2121 d 2121 ed within 73 Hygiene. other than		Elementary/Secondary (0-12) 6th	College (1-4 or 5+)		mployed		Air Cond	litioning
COD Iryland 2: Suld be filed will Mental Hygie marked other marked other	To Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Mai	iden Surname)	
ore, Maryland ore, Maryland or I and 2 should be filed of Health and Mental H (fem 27 is marked off	ľ	Unobtain 19a. Informant's Name/Relationship		19h Mailing Address	Rosa (Street and Number or Ru	Johnson ral Boute Number Co	itv or Town State Zi	n Code)
		Delores Pumphr		,	kdale Circ	Millana	ville MD	Nd 21108
altimore, mit. Page 1 and partment of Heal portant: If item? y injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3	☐ Removal from State 20b. Pla	ace of Disposition (Nan metery, crematory or o	ne of ther place)	Date 20	Oc. Location - City or	
Baltimo permit. Page Department o Important: If any injury or once.	ı	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	cify) Met	ro Crema			altimore	e, Md.
Balti Permit. Departi Importa any inji		Sarry H. 7	204	Wm 22 R	d Address of Facility eese & Son Forest Dr.	s Mortua Annapol	ry, PaA.	21401
		23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the death. one cause on each line.					Approximate Interval Between
Physician Medica		Immediate Cause (Final disease or condition resulting in death)	MYOC.	ARDIAL	INFA	RCTIC	N	Onset and Death
Examine			Due to (or as a conseque	ence of):				3 DAYS
	iner	Sequentially list conditions, if any, reading to incredicts cause. Enter Underlying	b. Due to (or as a nonseque	ince offe				
executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ence of):				
	1-		■ d					
OX 68760 ath certificate be eattending physicial for use as the burner of the burner o	/Med	IF FEMALE:	22a If was autooms of program					
a 8 a 8	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 D Ectopic	pregnancy pecify)		23d. Date of de Month	Day Year
P.O. s that the gned by t	वि	Part II. Other significant conditions	contributing to death but not resu	Iting in the underlying (cause given in Part I.			o the cause of death?
rds, equire	eted					1 L Yes		robably 4 Unknown
/ital Reco sician: The law r certificate has b	Completed					24a. Was an autopsy performe	prior to death?	completion of cause of
al B ian: Th itificat ctor, pê	Be Co	25. Was case referred to medical examiner?			26. Place of Death (Che	1 \textsquare Yes 2 \textsquare eck only one)	L) CNo 1 □ Ye	s 2 X No
f Vital Physician: this certific	ျ	1 Yes 2 No		R/Outpatient 3 D		Home 5 Residence		cify)
in of iding F. After 1. After	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year)	28b. Time of language 2 injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of Vital Records, tal or Attending Physician: The law requires s after death. In Director, After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	3 Suicide 6 Could not 4 Homicide determine	be 290 Place of Injury At hon	ne, farm, street, factor	y, office	28f. Location (Stree	et and Number or Ru State)	ral Route Number,
Division of V To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowle	idae death accurred o	t the time, date and place			tated
ne Hos n 24 hc ie Fune	Medical	(Check 2 Medical Exa	niner: On the best of my knowle miner: On the basis of examination urse Practitioner: To the best of my	and/or investigation, in	my opinion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.
To th withir To th	-	29b. Signature and title of certifier	South An	290	:. License number	290	d. Date signed (Mont	h. Dav. Year)
T		30. Name and address of person who		23a) (Time Print)	20001	411 1	04031	14,2012
dd		HARVINDER SI	N9H ARORA			ol Hosp D	R GLENI	BURNIE, MD 21061
Sta Regist		31. Date filed (Month Day Seat) 6	2012 32. Registrar's Signatu	b. bare	j			

		-	State of Maryland / Dep	partment of Health a		201	2 28474
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate of Death	2. Date of Dear		3. Time of Death
	Physicia Medic		John Robert Jennings		August	15, 2012 Year	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of De	
الر			Anne Arundel Medical Center	Annapolis		Anne Ar	undel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day,		Birthplace (State or Foreign Country)
			214-38-1877		2/2/19	934 Ma	ssachusetts
	land f shov	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-	irec		nsville			1 ☐ Yes 2 ☐XNo
	th the	ral	10e. Street and Number 1644 Crownsville Rd.	10f. Zip Code 21032		10g. Citizen of What o	Country?
	ems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13		n? (Specify Yes or No-		nerican Indian,
တ္တ	ter de , or it		1 LANever Married 2 L Married 1 L Yes 2 X No	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	Puerto Rican, etc.)	Black, Wh	nite, etc.
8	ours at tural" al Exa	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.				hite
7	72 ho n "na Aedio	nple	(Give	edent's Usual Occupation e <i>kind of work done during most o</i> DO NOT use retired)	of working	16b. Kind of Busines	ss/Industry Indel County
212	within giene. er tha the l		Elementary/Secondary (0-12) College (1-4 or 5+)	rosse Coach			Recreation
pu	filed all Hyg	o Be	17. Father's Name (First, Middle, Last)		's Name (First, Middle, A	,	
yla	uld be I Ment narke	오	John Jennings		lsie Houlke		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		. 1	iling Address <i>(Street and Number o</i> Heather Way, A			Zip Code)
re,	1 and if Heal item	1	20a. Method of Disposition 20b. Place of Disp	position (Name of		20c. Location - City	or Town, State
m	Page nent o ant: If Iry or			ematory or other place) Crematory 8	8/17/12	Edgewate	er, MD
alti	permit. Departr Importa any inju once.			22. Name and Address of Facility	George P. I	Kalas Fune	ral Home
ш	20 E E O		* fflille	2973 Solomons I			MD 21037
			23a. Rard 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
4	Physician/ Medical		Immediate Jause (Final disease or condition resulting in death) a. Due to (or as a consequence of):				0427
The state of the s	Examiner		2000 Company				OATS
	+	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. ACENTIO SACTER	-			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
200	icate l g phys	ledi	d				
89	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of	delivery
Box 687	the att	Physician/Me		Other (specify)		Month	Day Year
P.O.	requires that the der been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
S, T	ires the signeral ld be	Completed by	on Proste CA CAD		1 🗆 Ye	es 2 🗆 No 3 🗆	Probably 4 Unknown
ord	v requ	olete			24a. Was a		autopsy findings available
Sec	The law ate has page 2 s	lmo			autops perforr	ned? death	o completion of cause of ? 'es 2 No
<u>e</u>	Physician: The r this certificate beral director, page		25. Was case referred to medical examiner?	26. Place of Death		NOT I CO	03 2 2 110
\equiv	hysic this ce al dire	၉	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		sing Home 5 Reside	ence 6 Other (Sp	ecify)
n 0	ding F h. After funer	ate	27. Manner of Death 128a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year)	of 28c. Injury at work? M 1 □ Yes 2 □ N	1	w injury occurred	
Sio	Atten r deat ector: by the	Certificate:	2			reet and Number or F	Rural Route Number,
Division of Vital Records,	tal or rs afte al Dire		building, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check (estigation, in my opinion, death occu	urred at the time, date an	d place, and due to th	e cause(s) and manner stated.
	To the I within 2 To the I comple		only one) 3 Certifying Nurse Practitioner: To the best of my knowledg 29b. Signature and title of certifier	e, death occurred at the time, date		e cause(s) and manner 9d. Date signed (Mor	
	≓∋≓ŏ		V2-1-	P72199		8/17/1	L., Day, roar)
	10,0		30. Name and addless of person who completed cause of death (Item 23a) (Type,	Print)		0171	
	1 W		K. Norge 20	of medical po	trhway A	mpolis,	hd 21411
	Stat Registra	e	31. Date filed (Month, 195 ^Y 2r) 0 3012 32. Registrar's Signature	banks.	٧		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	ate of Maryland / I	•	ificate of D			eg. No. 201	2 28475
	Physicia		1. Decedent's Name (First, Middle, Last) Raymond Walter Klin	e				2. Date of Deat Month Aug	h 2 ^{Day} 201 ^{Yan}	3. Time of Death 12:30 p M
	Medic Examin		4a. Facility Name (if not institution, give street a	nd number)		4b. City, Town, or l			4c. County of De	
34	Funeral		8939 Old Harmony Roa 5. Social Security Number 6. Sex		thday)	Myersvil If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	lirthplace (State or Foreign
	Director		214-30-1755 14 M 2	¹ 78	Yrs.	Widnins Days	Hours Will.	Jan. 31	^{Year)} 1934	Maryland
	yland -f shov ed at	ctor	10a. State 10b. County	10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 2√√ No
	he Mar or 28a e notif	Funeral Director	Maryland Frederick 10e. Street and Number	Myers	SVILI	10f, Zip Code			10g. Citizen of What (
	n with is 23a nust b	neral	8939 Old Harmony Roa			21773			United St	
036	2 should be filed within 72 hours after death with the Maryland than dhertally typiene. At and Mentally typiene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 X Married 1	is Decedent Ever in U.S. ged Forces? AYes 2 No es, Give 1949-54 ar or Dates, 1949-54	- 1	as Decedent of His Yes, specify Cuban Yes 2 XNo		city Yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. hite
Baltimore, Maryland 21215-0036	72 hour n "natu 1edical	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	(Give ki	ent's Usual Occupating of work done du NOT use retired)	tion uring most of work	ing	16b. Kind of Busines	s Industry
212	within ygiene.	امدا	12	llege (1-4 or 5+)		contracto			construc	tion
and	be filed ental H rked ott ic even	To Be	17. Father's Name (First, Middle, Last) Raymond M. Kline				18. Mother's Nam Beulah		<i>flaiden Surname)</i>	
/Jary	should be file and Mental ris marked or raumatic eve		19a. Informant's Name/Relationship (Type, Prir Constance Kline / wi	fo					City or Town, State,	
ē,	1 and 2 s f Health item 27 other tra		20a. Method of Disposition	20b. Place of	of Dispos	Old Harm ition (Name of atory or other place			Le, MD 2 20c. Location - City	1773 or Town, State
t <u>i</u> mo	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		1 X Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	Salen	n U.	Methodis	t Aug.	28, 201		ille, MD
Ba	permit Depar Impor any in	- 10	21. Signatura Service n	1		Name and Address		ame.	04 Main S [versville	
· · · · ·	Medical Examiner by physician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Oue to (or as a consequence	of):		Can			Approximate Interval Between Inset and Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	res, outcome of pregnancy Live Birth 2 Fetal deat Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)	/		23d. Date of o Month	delivery Day Year
, P.O.	es that the igned by be deta	by	Part II. Other significant conditions contribut	ing to death but not resulting	in the ur	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown
Records,	he law requires that t te has been signed b age 2 should be dett	Completed						24a. Was a autop: perfor	n 24b. Were prior t death	autopsy findings available o completion of cause of
talF	hysician: The law his certificate has l I director, page 2 s	Be	25. Was case referred to medical examiner?	i:		Othe	r:	k only one)		
of Vi	g Physicer this control dir	te: To	1 L Yes 2 L No	1 ☐ Inpatient 2 ☐ ER/O	Outpatient Time of injury	t 3 DOA 28c. Injury	4 ☐ Nursing Heat	· · · · · · · · · · · · · · · · · · ·	ence 6 Other (Sp ow injury occurred	ecify)
Division of Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	2 Accident Investigation	e. Place of Injury - At home, fi building, etc. (Specify)		M 1 □ `	Yes 2 No	28f. Location (Si City or Town	treet and Number or I n, State)	Rural Route Number,
	Hospita 14 hours Funeral ted fillec	Medical	(Check / 2) Medical Examiner: Or	To the best of my knowledge, the basis of examination and/	or investi	gation, in my opinion	n, death occurred a	t the time, date ar	nd place, and due to the	ne cause(s) and manner stated.
	To the within 2 To the Comple	M	only one) 3 Certifying Nurse Prace 29b. Signature and title of certifier	tioner: To the best of my know	wledge, d	eath occurred at the 29c. License			cause(s) and manner	
	8 m		30. Name and address of person who complet	ed cause of death (Item 23a)	(Type, P	Drive	Frede	seh	MD 21	702
	Sta		31. Date filed (Month, Day, Year) SFD 0 6 2012	37. Registrar's Signature	has	Kee				

			For State	State of Maryla		artment of F		/lental Hy	201	2 201.76
			Registrar 1. Decedent's Name (First, Middle, I	.ast)	Cer	uncate of L	<u> </u>	2. Date of De	Reg. No. Z U	2 28476
	Physicia Medic		Lester McLai	n Luhn				Auz	18 20	3. Time of Death 4:5/ PM
	Examir		4a. Facility Name (if not institution, g 5+. Agnes	ive street and number)		4b. City Town, or	Location of Death mO(l	0	4c. County of E	Death
8	Funeral Director		5. Social Security Number 215-26-8756 Usual Residence of Decedent	. Sex 7. Age (In yrs 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/15/	y, Year)	Birthplace (State or Foreign Country) [aryland]
	land show dat	tor	10a. State 10b. County	10c. C	ity, Town or Lo	cation	<u> </u>	I.		10d. Inside City Limits
	Mary 28a-f notifie	irec	MD Kent		Rock Ha					1 X Yes 2 □ No
	n with the	Funeral Director	10e. Street and Number 5945 N. Main St	reet		10f. Zip Code 216			10g. Citizen of What United St	
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to T Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	þ	 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced 	12. Was Decedent Ever in L Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. 1951.		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify: V	American Indian, Vhite, etc. Vhite
Maryland 21215-0036	iin 72 hour ie. han "natu e Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give . life. D	O NOT use retired)	luring most of work	ing	16b. Kind of Busin	ess/Industry
d 21	ed with Hygien other ti	Be C	12 17. Father's Name (First, Middle, Las		P1u	mber/pipe		o (Eiret Middle	Plumbing Maiden Surname)	2
<u>/lano</u>	d be file Mental I arked c	10F	Charles Bradle	,				Martha		
Man	and 2 shoul Health and I tem 27 is m		19a. Informant's Name/Relationship Thomas G. Luhn		1				r, City or Town, State	
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 4 🗍 Donation 5 🗍 Other (Spe	Removal from State	cemetery, crer.	sition (Name of natory or other plac	e) .	Date / 2012	20c. Location - City	
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service Lio		22	. Name and Addres	ss of Facility Šta i	ıffer F	uneral Hon	nes, P.A.
	20200		23a. Part 1. Enter the disease, or co	omplications that caused the de					ederick, M	Approximate
	Physician/ Medical		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	= Septic		cK				Interval Between Onset and Death
	Examiner			Due to (or as a conse	150					3 DAYS
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	e execut cian and curial-tra	dical Exa	that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):					
09/	icate by physicate but the key	ledic		d	7					
. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year
ds, P.O.	requires that the des been signed by the s should be detached	ρ	Part II. Other significant conditions	s contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 \Unknown
ter Records,	sician: The law rec certificate has bee lirector, page 2 sho	Completed							osy prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
ital	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ace of Death (Checker:			
J _o	ig Physter this	te: To	27. Manner of Death	1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury		at		dence 6 Other (S now injury occurred	pecify)
Sign	Attending or death. sctor: After by the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	t he		M 1 🗆	Yes 2 No			
Why Ly	tal or A	Cer	4 Homicide determine	28e. Place of Injury - At I building, etc. (Speci	fy)	eet, factory, office		28f. Location (S City or Tou		Rural Route Number,
7	T 2 L #	Medical ((Check 2 \(\subseteq Medical Exa	hysician: To the best of my kno miner: On the basis of examinati urse Practitioner: To the best o	on and/or inves	igation, in my opinic	n, death occurred at	the time, date a	and place, and due to t	the cause(s) and manner stated.
	To the within 7 To the comple		29b. Signature and title of certifier	PGY3 MEDI	CAL	29c. License		2	29d. Date signed (M	
	(k)		30. Name and address of person whe		m 23a) (Type, F	rint) 100 S	caton A	renue,	Baltimon,	MD-21229.
	Star Registra	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
			1100							

Lagana, Unda L.

				Pleas	e Type or Pi						-		_	le.		
			For State Registrar		State of N	vlarylan		artment of rtificate of		and Me	entai Hy	giene Reg. No	20	2	28	1.77
	Dhysinis	/	1. Decedent's Nam	e (First, Middle, L	ast)			tinoato or			2. Date of De	ath			3. Time	of Death
	Physicia Medi	al	Linda		ana			T # 00 T			August			12	09	45 M
ment,	Examir		Annl. And 5. Social Security N	undel 1	ve street and number, MUCLU Sex 7.A	CLN to	est hirthday	4b. City, Town, M N (1) If Under 1 Year	polis	2	8. Date of Bir	A	nne Nne	m	unde	or Foreign
	Funeral Director		213-44- Usual Residence	4482	1 M 2 X F	65	Yrs.	Months Days		Min.	03/04/	y, Year)		Count	ry)	n, DC
	yland f shov ed at	tor	10a. State	10b. County			y, Town or La							10		City Limits
	ne Mar nr 28a- notifi	Dire	Maryland 10e. Street and Nur	Anne Ar	undel	Dav	ridson	ville 10f. Zip Code				10a C	itizen of Wha	t Count		es 2 X No
	with the s 23a c ust be	Funeral Director	1512 Pat	uxent Ma	nor Road			21035	5			_	ited S		-	
	death r items ner m	Fun	11. Marital Status		12. Was Deceden Armed Forces	?	3. 13.	Was Decedent of I	Hispanic Or pan, Mexica	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - A			
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	eted by	1 ☐ Never Marr 3 🏋 Widowed		If Yes, Give Year or Dates.			1 ☐ Yes 2 📈 N		y:			Specify:	Whi	te	
215-	72 hc an "na Medic	Completed	(Spe		grade completed) College (1-4 or	r.5.1)	(Give	dent's Usual Occu kind of work done O NOT use retired	during mos	st of working)	16b. ł	Kind of Busin	ess/Ind	ustry	
	J withir ygiene her th	Be Co	12			1 3+)	Payro	oll Manag	Ť				avel			
and	ntal H ced of	70 B	17. Father's Name (,	First, Middle, Todd F		,			
Maryland	hould I and Me s mark umati		19a. Informant's Na				19b. Mailii	ng Address (Stree						e, Zip Ci	ode)	
Σ	nd 2 s lealth a m 27 i		Ronald L		n			Bear De	n Rd.,	, Fred	erick,	MD	2170	1		
Saltimore,	ermit. Page 1 and 2 sl Lepertment of Health a mpc rtant: If item 27 is ny njury or other tra cnes.		20a. Method of Disp 1 X Burial 2	Cremation 3	Removal from State	te c	emetery, crer	osition (Name of matory or other pla		Da			ocation - Cit	•		
altin	ermit. Page epertmer mpc rtant ny njury nce.		4 ☐ Donation 21. Signatur	5 Other (Spe		Lak		Cemetery Name and Addr		08/2	2/2012	Dav Vol	idson	vill	e, Ma	aryl <u>an</u> o
Ö	mpc mpc ny r	JIV.	1/m	1/6	2			2973 Sol	omons	Islan	d Rd.,	Edg	as run gewate	r, l	MD 21	.037
	Physician/	. 9	sheek, or hear Immediate Cause (disease or condition	rt failure. List only Final	mplications that caus one cause on each li			er the mode of dyi			respiratory ar	rest,			Approxima Interval Be Onset and	etween
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	ed	Examiner	Sequentially list co cause. Enter Under Cause (Disease or	rlying	b. Due to for a	s a consequ	ience of									
	e executed sian and urial-transit		that initiated events resulting in death)	s	c. Due to (or a	s a consequ	ence of):							+		<u>;</u>
68760	cate be physic s the b	edic			d									\perp		
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.		IF FEMALE: 23b. Was decedent in the past 12 t 1 ☐ Yes 2,↓ 9 ☐ Unknown	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 🗌 Feta t at time of d	I death 3	Ectopic pregnar Other (specify)	псу				23d. Date o Month		ry Day	Year
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al R	sician: The law i certificate has k lirector, page 2 s		25. Was case referre	ed to medical				26. F	Place of Dea	ath (Check o	1 \(\sime\) Yes	2 L N	lo] 1 L	Yes 2	2 🗌 No	
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n o	th. After e funer	cate	1 Natural 2 Accident	5 Pending Investigati	28a. Date of in (Month, D		28b. Time of injury	Wol	iry at 'k?] Yes 2 □		ld. Describe h	now injur	ry occurred			
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific, completely filled in by the funeral director.	Certificate:	3 Suicide 4 Homicide	6 Could not determine	be 28e. Place of Ir	njury - At ho etc. (Specify)		eet, factory, office		28	If. Location (S City or Tov			r Rural I	Route Num	nber,
	Hospital 24 hours Funeral etely filled	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of urse Practitioner: To	examination	and/or inves	tigation, in my opin	ion, death o	occurred at the	ne time, date a	and place	e, and due to	the caus	se(s) and m	nanner stated.
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	310-311			-	Method		7"									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2012^{Ye} 3:00PM August Eila Annikki Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Future Care Chesapeake Arnold If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. B. Date of Birth (Month, Day, Year 3/15/1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Voor Months 1 □ M 2/CXF Finland Director 80 185-40-7538 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show the Medical Exercitor Fuel be notified at Director 1**x** Yes 2 ☐ No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21403 1039 Pinecrest Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: Be Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Banking Customer Service 18. Mother's Name (First, Middle, Maiden Surname) ukn 17. Father's Name (First, Middle, Last) 11kn traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health a Important: If item 27 is any injury or other trau 1553 Star Pine Drive, Annapolis, MD 21409 Kirsi Lewis - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 8/17/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myclin Tillo 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebro Immediate Cause (Final hysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, physician the. attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown icate has been signed; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 ₽No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Atural 5 Pending within 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10073574 30. Name and address of persol who completed cause of death (Item 23a) (Type, Print) Natural Karincova, 8601 VR HE ZAUS HWY, a 10 Suite 204, Miller Stille, 31. Date filed (Month

DHMH 17 Rev 1/2001

State Registrar 12-06385 Ethan C. Lee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 28479

			1- For State Registrar	Certificate c	of Death	Re	g. No.	
Substantial Substa		an/	Decedent's Name (First, Middle,Last)			2. Date of Death Month August 24,	Day Year 2012	3. Time of Death 1235 hrs
219-17-8231					•	f Death	4c. County of Death Montgomery	
To Seed that Number 10 months 10 month			210 17 0221	12	Months Days Hours	Min	Foreign	
Table Tabl	* .,,	٥٢	10a. State 10b. County 10c. C	City, Town or Loca		rille		
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The state of the s			b	ce of):				
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The past 12 months? past 12 months? past 12	se exection and inial - to	dica	▼ UNPENDED	,28a-f,p	er me,g931 9-	10-12 sm		
296. Signature and title of certifier O.C.M.E. August 25, 2012	3760 ficate b g physi s the bu		23b. Was decedent pregnant in the 1 Live birth		etal death 3 Ectopic	pregnancy		
296. Signature and title of certifier O.C.M.E. August 25, 2012	x 68 th certi trendin r use as	siciar	past 12 months? 4 Pregnant at time o	f. 12 - 11		F1-03-12-10-y		-7
296. Signature and title of certifier O.C.M.E. August 25, 2012	the dea by the a	Phys	a la la la la la la la la la la la la la	ot resulting in the	underlying cause given in Pa	rt I. 23e, Did to	bacco use contribute to t	he cause of death?
296. Signature and title of certifier O.C.M.E. August 25, 2012	P.C res that signed b	þ					2 ✓ No 3 Prob	ably 4 Unknown
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296. Signature and title of certifier O.C.M.E. August 25, 2012	Rec C The lar cate ha	Jom J					med? death? 2 No 1 ✔ Ye	s 2 No
296. Signature and title of certifier O.C.M.E. August 25, 2012	icien: s certifi rector,	Be	examiner? Hospital: 1 Inneticet 3	☐ ER/Outpatier			Residence 6 Other	Scene
296. Signature and title of certifier O.C.M.E. August 25, 2012	of V ig Phys fter thi neral di		1 Yes 2 No 27. Manner of Death 28a. Date of Injury	<u> </u>				
296. Signature and title of certifier O.C.M.E. August 25, 2012	ion frendin feath. ster: A	atio	Natural 5 Pending Accident Investigation fd 8-24-12		10 pml			
296. Signature and title of certifier O.C.M.E. August 25, 2012	Oiris sere ed.nby	rtific	Suicide 6 🔀 Could not be determined (Specify) 🗲		eet, factory, office building, et	or Town, St	tate) 7 Goodport	raf Route Number, City
296. Signature and title of certifier O.C.M.E. August 25, 2012	the Hospit thin 24 hour the Funera		29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination	vledge, death occi	urred at the time, date and pla ation, in my opinion, death oc	ce, and due to the cause	e(s) and manner as state	ed e cause(s)
Chille - Other	To wit	Me					,	th, Day, Year)
20. Name and address of person who completed cause of death (Item 23a)			Kotu (- Yollu		O.C.M.E.		August 25, 2012	
Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			30. Name and address of person who completed cause of death (I Patricia Aronica-Pollak MD. Assistant Medic		900 W. Baltimore Str	eet, Baltimore, MI	D 21223	
	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Sign					
31. Date filed (Month, Day, Year) 32. Registrar's Signature			SEP 0 6 2012 June 1.		/			

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n nga	Medic Examin		Susan Elizabeth Micoloc 4a. Facility Name (if not institution, give street and number)	nick	4b. City, Town, or	Location of Death	August	4c. County		7:36 A. ^M
_0			335 W. Main Street 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birtho	Thurmo	nt If Under 24 Hrs.	8. Date of Birth	Fred	derick	Nace (State or Foreign
	Funeral Director		033-56-4639 1 □ M 2 🗓 F		Months Days	Hours Min.	(Month, Day,		Coun	try) sylvania
	and show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		127,207,1			0d. Inside City Limits
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	th the	ralD	10e. Street and Number	•	10f. Zip Code	01700	1	0g. Citizen of	What Coun	-
	eath w	Funeral	335 West Main Street 11. Marital Status 12. Was Decedent I	Ever in U.S.	13. Was Decedent of Hi	21788 spanic Origin? (Spe	ecify Yes or No-		ce - Americ	
9	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ 1 ☐ Yes, Give Year or Dates	No .	If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	n, Mexican, Puerto	Rican, etc.)	Bla Specify	ck, White, e	
Maryland 21215-0036	hours natura lical E	Completed	15. Decedent's Education		Decedent's Usual Occupa			16b. Kind of E	******	
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ylan	ld be fi Mental arked atic ev	₽ 2	James Spaid			Alice F	ischer			
Mar	2 shou th and 27 is m traum	-	19a. Informant's Name/Relationship (Type, Print)	1/4	Mailing Address (Street a					
	of Heall fitem 2		Kristopher Flaherty/ Friend 20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other place			20c. Location		
altımore,	ment of tant; If inny or		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		er Crematory		1/2012	Freder	ick,M	aryland.
Rail	permit. Page Department of Important; If any injury or once.		21. Signature of Lineral Service Licensee		22. Name and Addres Stauffer I 1621 Oposs	s of Facility Funeral H Sumfown P	omes P. ike. Fre	A. derick	.Marv	land 21702
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у. О.	at the o	Phy	g Unknown Part II. Other significant conditions contributing to death be	out not resulting in	the underlying cause giv	ren in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
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Division of	Attend r death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ury - At home, farn	M 1 L	Yes 2 ☐ No	28f. Location (Str	eet and Numb	per or Rural	Route Number,
<u>></u>	ital or us after all Dire		building, etc	- 1			City or Town	· · · · · · · · · · · · · · · · · · ·		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of e	examination and/or i	investigation, in my opinio	n, death occurred at	t the time, date and	d place, and du	ue to the cau	use(s) and manner stated.
_	To the within To the comp	2	29b Signature and title of certifier	\	29c. License			9d. Date signe		
,			MA-C-1+EGHTC	(MI)	una Print)	4410	4	8/	20/2	012
	9		30. Name and Address of person who completed cause of d	DVW	re Frede	ruch V	10,21	702		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CAROL EUGENE MILLS AUG. 2012 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NMS HEALTHCARE HAGERSTOWN HAGERSTOWN WASHINGTON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗓 M 2 🗆 F 671071930 82 **Director** 234-36-6329 Usual Residence of Decedent 28a-f show 10a. State with the Maryland items 23a or 28a-f sho ler must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD WASHINGTON HAGERSTOWN 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14014 MARK PIKE 21742 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces Black, White, etc. 6 þ 1 Never Married 2 Married 1XX Yes 2 [If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify WHITE Specify: "natural" Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ul Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING MACHINIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname and Mental 0 SAMUEL WALKER THOMAS MILLS BESSIE AGNES GAYNOR traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. CAROL GARRETT/DAUGHTER 911 HILLCREST DR., MARTINSBURG, WV 25401 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 AUG. Data. 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State SMITHSBURG CREMATORY SMITHSBURG, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 254Ó2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eachine. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DIONGIL Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) as the burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? ō Month Pregnant at time of death Day Year 2 No the Unknown 9 Unknown has been signed by tl e 2 should be detach∈ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page performed? Yes 2 No certificate ! 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔊 No 1 Tes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 옏 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De h 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending iniury 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Name and addr

cphanic

31. Date filed (Month, Day, Year)

14014

MLISH

ss of person who completed cause of death (Item 23a) (Type, Print)

oncosdin

32. Registrar's Signature

		Please Type or	Print in	Black	Indelible In	k. Ensure	All Copie	es Ar	e Legi	ble.	
			Marylan	nd / Dep	partment of	Health and	Mental H	ygien	е		
		State Registrar		Ce	ertificate of	Death		Reg. N	10.20	12	28482
Physicia	an/	1. Decedent's Name (First, Middle, Last)					2. Date of D		ay oo 1 c	Year	3. Time of Death
Medic Examir		Evelyn B. Martin 4a. Facility Name (if not institution, give street and number)	ner)		4b City Tours	and agation of Door		-			7:38 P M
LAGIIII	lei	12301 Piedmont Road	,,,,			or Location of Deat rksburg	n	4	c. County c	of Death Egome	≥rv
Funeral	Г		'. Age (In yrs. la	ast birthday		If Under 24 Hrs		irth		9. Birthp	olace (State or Foreign
Director		Usual Residence of Decedent	92	Yrs.	World S Days	Tiours William	April			Count	ryland
land show d at	ě	10a. State 10b. County	10c. City	y, Town or L	ocation						Od. Inside City Limits
Maryi 28a-f otifie	irec	Maryland Montgomery		Clark	sburg						1 ☐ Yes 🏋 ☐ No
h the	al D	10e. Street and Number			10f. Zip Code			10g. C	itizen of W	hat Coun	itry?
ms 2%	Funeral Director	12301 Piedmont Road				20871			USA		
er dea or ite niner	by Fu	11. Marital Status 12. Was Deceded Armed Ford 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	ent Ever in U.S es? • IXI No	5. 13	. Was Decedent of H If Yes, specify Cubi		pecify Yes or No o Rican, etc.))-	14. Race Black	- America , White, e	
ırs aftı ıral", Exar	ed k	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dat			1 🗌 Yes 2 🕅 No	Specify:			Specify:	Whit	e
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)			edent's Usual Occur e kind of work done		rkina	16b. l	Kind of Bus		
ithin 7 ene. than	Com	Elementary/Secondary (0-12) College (1-4	or 5+)	life.	DO NOT use retired)		Mirg	ĺ			
lled w Hygi other	Be	17. Father's Name (First, Middle, Last)		ВО	ok Bindin	18. Mother's Na	me (First Middle	Maiden		<u>ubli</u>	shing
d be fi //enta arked tic ev	ပ	Franklin L. Martin					erine Be		Surname		
shoulk and N is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mai	ling Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, Sta	ite, Zip C	ode)
and 2 Health		Becky Free / Granddaugh		1.	4624 Wood	spring Co	ourt, Ce	enter	rvill	e. V	A 20120
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from S	tate C6	lace of Disp emetery, cre	osition (Name of ematory or other plac	ce)	Date	20c. L	ocation - C	City or Tov	wn, State
nit. Pa artme ortan injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Mt	. 01i	22. Name and Addre		7/2012		reder: r Fune		Maryland
Depar Impo any ir		Josephan Stoub	11.			,					MD 21702
		23a. Part 1. Enter the disease, or complications that ca shook, or heart failure. List only one cause on back	ed the death	n. Do not en							Approximate
Physician/		Immediate Cause (Final disease or condition	no notice	10 h	past L	oilus o					Interval Between Onset and Death
Medical Examiner		resulting in death) a. Due to (or	as a consequ	ence of):	1	unity V				\top	7 - H.
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or	as a conseque	TC (tenesis					_	3 months
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	ao a conocqui	01100 017.							
e executed cian and ourial-transit	al Ex	that initiated events c. Due to (or	as a conseque	ence of):						\top	
law requires that the death certificate be executed nas been signed by the attending physician and e 2 should be detached for use as the burial-transi	dica	d									
eath certifica attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	me of oregon	acv.							
atten atten I for u	iciar	in the past 12 months?		death 3	Ectopic pregnanc	ру			23d. Date Month		ry Day Year
the de by the ached	hys	9 Unknown 9 Unkno									
requires that the de been signed by the s should be detached		Part II. Other significant conditions contributing to dea	1		underlying cause giv	en in Part I.	23e. Did t	obacco i	use contrib	ute to the	e cause of death?
equire een si nould	ted	Coronary artery a	islas	l			1 🗆	Yes 2	No 3	☐ Proba	ably 4 🗌 Unknown
law n has b je 2 sł	Completed by	/					24a. Was auto	psy	pric	or to com	sy findings available pletion of cause of
n: The ficate or, pag		25. Was case referred to medical					1 Yes	ormed? 2 X No		ath? Yes 2	2 🗆 No
Physician: The law this certificate has al director, page 2	To Be	examiner?	entions O 🗆 5	D/O-441-	Oak	ace of Death (Checer:					
ng Phy ter this neral	te: T	27. Manner of Death 28a. Date of	oatient 2 E injury 2 Day, Year)	28b. Time o injury	f 28c. Injury	4 □ Nursing H	28d. Describe			Specify)	
tendir leath. or: Af the fu	ifica	1 Natural 5 Pending (Month, 2 Accident Investigation 3 Suicide 6 Could not be	Day, rear)	injury	M 1 🗆	Yes 2 No					
or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of	Injury - At hon etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tov			or Rural F	Route Number,
		29a. Certifier 1 Certifying Physician: To the bes	of my knowle	dae death	occurred at the time	date and place	and due to the c	21122(2) 21	nd mannar		
ne Ho in 24 h ne Fur pletely	Medical	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner: To	of examination :	and/or inves	tidation, in my opinio	in death occurred a	t the time date of	and place	and due to	the equa	ac(a) and manner stated
Nithin To th		29b. Signature and title of certifier	11	1	29c. License				te signed (A		
		Teak	1	- N	10 D	57362		llug	ust 1	4,	2012
10		30. Name and address of person who completed cause of	death (Item 2	23a) (Type, F	Print)	C 10	rsburg	0	15	~ ()-1	2012 9
State	9	31. Date filed (Month, Day, Year) 32. Feg	2 Wa strar's Sig <i>n</i> atu	TKINS re	IVIII Kd.	- Jame	Bburg	1 10	10 20	181	7
Registra		AUG 2 U 2012	9.5.6.ml	h la	model						

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or Pri			delible Ink					Legible.	
	•	For State Registrar	State of M	aryland		tificate of E		and Men		_	2012	2 28483
Physicia	n/	1. Decedent's Name (First, Middle, I	,						Date of De	ath		3. Time of Death
Medic	al	Margie Marie Marie Marsie Margie Marie Margie Marie Marie Marie Margin M							ugust		, 20°12	10:02 A M
Examin	er	1102 Indian Land				4b. City, Town, or Millers					County of Deat nne Aru	
Funeral		Social Security Number		e (În yrs. las	st birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. [Date of Birt Month, Da	th	9. Birt	hplace (State or Foreign intry)
Director		236-32-7779 Usual Residence of Decedent	1 □ M 2 🗓 F	89	Yrs.	Month's Days	riouis	,	2/03/		002	KY
land show dat	to	10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
Mary 28a-f	irec	MD Anne An	undel	Mill(ersvil							1 🗌 Yes 2 🗶 No
ith the	Funeral Director	10e. Street and Number 1102 Indian Land	dina Dd			10f. Zip Code 21108			1	10g. Citiz	en of What Co US	
eath w	-une	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. W	as Decedent of His	spanic Orig	gin? (Specify)	Yes or No-	1	4. Race - Amei	
after d ", or i	þ	1 Never Married 2 Marrie	d Armed Forces? 1 ☐ Yes 2 ▼	No		Yes, specify Cubar ☐ Yes 2 ☑ No		, Puerto Ricar	n, etc.)		Black, White	
atural	eted	3 X Widowed 4 Divorced	Year or Dates.			ent's Usual Occupa					pecify: Whi	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest Elementary/Secondary (0-12) 12		5+)	(Give ki life. DC	ind of work done d NOT use retired) tionist		of working			alth ca	
lled wi Hygie other rent, tl	Be	17. Father's Name (First, Middle, Las	st)		тесер	CIONISC	18. Mothe	er's Name (Firs	st, Middle,			Te
ld be f Menta arked atic ev	잍	Hayes Johnson					Dora	Litt	le_			
shou h and 7 is m traum		19a. Informant's Name/Relationship				g Address (Street a						*
f Healt f Healt item 2 other		Timothy R. Menge 20a. Method of Disposition	ele (son)	20b. Pla	ace of Dispos	uttonwood		ail C	rowns		e, MD 2	
Page Tent o ant: If		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	Mar	metery, crem y \mathtt{land}	atory or other place Veteran (e) Cem. (2012		wnsvill	
permit. Departn Imports any inju		21. Signature of Funeral Service Lic	ensee		22.	Name and Addres	s of Facility	Hard	esty	Fune	ral Hom	eP.A.
00 = a 0		23a. Part 1. Enter the disease, or co	omplications that caused	I the death		51 Annapo					D 21054	-00
Physician/		shock, or heart failure. List onl Immediate Cause (Final			C C	fbo	1	Jaidiao of Too	piratory an	icst,		Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	116/6	217					
Examiner	er	Sequentially list conditions,	b. ——									
ted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	rice oi):							
execu an and irial-tra	_ [that initiated events resulting in death) Last	C. Due to (or as a	a conseque	nce of):							
ath certificate be executed attending physician and for use as the burial-transit	dica		d									
certific nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				-			2'	3d. Date of deli	wen.
death of atter	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnancy Other (specify)	У				Month	Day Year
at the		9 Unknown Part II. Other significant conditions		ut not resul	ting in the un	derlying cause give	en in Part I.		23a Did to	phaces us	a contribute to	the cause of death?
ires th signe	d by					, 5			1 🗆 1	1	/	obably 4 Unknown
w requ	Completed								24a. Was		24b. Were aut	opsy findings available ompletion of cause of
The la	Com						-		autop perfo 1 Yes	riced?	death?	2 No
ician: Sertific rector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla		h (Check only		7		
r this eral dii	은 :a	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatie	ry 2	R/Outpatient 8b. Time of	3 DOA Other	4 ∐ Nur		5 Resid		Other (Special	fy)
anding sath. rr: Afte he fun	ficat	Natural 5 Pending 2 Accident Investigat		r, Year)	injury	work?			Dogoribo II	low injury (Socialica	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	3 Suicide 6 Could no 4 Homicide determine			ne, farm, stree	et, factory, office			ocation (S Dity or Tow		Number or Run	al Route Number,
ospital hours uneral ly fillec	cal	29a. Certifier Certifying P	hysician: To the best of	my knowle	dge, death or	curred at the time,	, date and p	place, and du	e to the ca	use(s) and	I manner as sta	ited.
the Hi hin 24 the Fu	Mec	(Check 2 Medical Exa	urse Practitioner: To the	e best of my	and/or investig knowledge, c	gation, in my opinior leath occurred at th	n, death occ le time, date	curred at the ti	me, date a	nd place, a he cause(s)	and due to the c and manner as	ause(s) and manner stated stated.
2 ½ 2 ⊗		29b. Signature and title of certifier	liamb 110	2		29c. License	number 283	0		29d. Date	signed (Month,	Day, Year)
	ŀ	30. Name and address of person wh	o completed cause of de	eath (Item 2	3a) (Type, Pr	nt)				1109	// / / / /	~ (
1510	_	(Check only one) 3 Certifying N 29b. Signature and title of certifier August 40 30. Name and address of person wh Clare W2 W3 31. Date filed (Month, Day, Year)	, MD, 200	3 M	edice	al person	Cucy	#21	10 A	ma	alis,1	10715 an
Stat Registra	e	31. Date filed (Month, Day, Year)	32. Pegistra	ır's Signatu	re	41	,			1		

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Pı						_		_	ble.	
	-	For State		State of N	/larylan		artment of F rtificate of D		id M	1ental Hy	_	20	12	28484
		Registrar 1. Decedent's Name	e (First, Middle, L	ast)		Cer	tilicate of L	Jeann		2. Date of De	Reg. N	o. Z U	16	3. Time of Death
Physicia Medic		Margaret	K. Ma	yer						Aug.	15, ^D	^{ay} 201	Ž ^{ear}	12:18 PM
Examin		4a. Facility Name (if		ve street and number)			4b. City, Town, or	Location of D	eath		4	c. County o		
(ter		Crofton		C 17.0			Crofton		Urc	0 0 0 0 0 0	- I	Anne		
Funeral Director		5. Social Security N 558-52-6		Sex 7. A	ige (In yrs. 16 96	ast birthday) Yrs.	Months Days	Hours N	vin.	8. Date of Bir	ay, Year)		9. Birthp	37 — —
		Usual Residence	of Decedent							07/05/	1910	0		IL
yland -f sho ed at	ctor	10a. State	10b. County			y, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2√2 No
ne Mar or 28a notifi	Dire	MD 10e. Street and Nur	Anne Ar	undel	Ga	mbrill	S 10f. Zip Code				10a. C	Citizen of W	hat Coun	
with the	Funeral Director		shine Wa	ıy -			21054	+			, eg. e		SA	-,-
death items ier mu	Fu	11. Marital Status		12. Was Deceden Armed Forces		S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin'	? (Spe	ecify Yes or No- Rican, etc.)			- Americ	an Indian,
after c	py	1 Never Marr 3 Widowed	ried 2 Married	1 ☐ Yes 2X If Yes, Give	No		1 ☐ Yes 2 🛣 No		40.10	r nodin, oton		Specify:		ite
ours atura cal E	Completed	3 Let Wildowed	15. Decedent's	Year or Dates. Education		16a. Dece	dent's Usual Occup	ation			16b.	Kind of Bu	siness/Inc	dustry
in 72 h e. nan "n Medi	dmc	(Spe	ondary (0-12)	grade completed) College (1-4 or	r 5+)	life. D	kind of work done o O NOT use retired)							,
d with lygien ther th	Be Co	12	2			Admin	istrative					.S.D.		
oe filed Intal H ced of	일	17. Father's Name (18. Mother's Mary		e (First, Middle 1 e o n	, Maider	n Surname)		
nould k		19a. Informant's Na				19b. Maili	ng Address (Street a				er, City o	or Town, St	ate, Zip C	Dode)
id 2 sh ealth a n 27 is ertrau		Mary Lou	Harris	(daught	er)		Sunshine							
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	position X Cremation 3	Removal from State	20b. F	Place of Dispo cemetery, crer	osition (Name of matory or other place			Date		Location -	_	
t. Pag rtment rtant:		4 Donation	5 Other (Spe	cify)	At1		Crematory			/2012		en Bu		-
permi Depar Impo any ir once.		21. Signature of Fu	ineral Service Lice	nsee			2. Name and Addres 51 Annapo							P.A.
		23a. Part 1. Enter	the disease or co	mplications that caus	ed the deat							.ш ет		Approximate
₽hysician/		Immediate Cause disease or condition	(Final	one cause on each li	ne. Uenti	4								Interval Between Onset and Death
Medical Examiner		resulting in death)	•		s a consequ									
	er	Sequentially list co	onditions,	b. Due to (or a	s a consequ	nence off:								
ted I ansit	Examiner	cause. Enter Unde Cause (Disease or	erlying S	Dac to (01 a	o a concequ	301100 017.								
e executed cian and curial-transit	al Ex	that initiated event resulting in death)		Due to (or a	s a consequ	uence of):								
cate be physici s the bu	dica		•	d									-	
eath certifica attending pl	/Me	IF FEMALE:		23c. If yes, outcom	ne of pregna	ancy						23d. Date	of delive	201
eath c atten d for u	iciar	23b. Was decedent in the past 12 1 Yes 2	months?	1 ☐ Live Birth 4 ☐ Pregnant	n 2 🗌 Feta t at time of o	al death 3 L	Ectopic pregnand Other (specify)	су				Mor		Day Year
t the dea by the a stached	Physician/Medic	9 Unknown	n e	9 Unknowr										
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	by	Part II. Other signi	A .	al fibiile		sulting in the t	underlying cause giv	ven in Part I.						ne cause of death?
require been s should	Completed) /	w pir						24a. Was				osy findings available
The law ate has I page 2 s	Jup									auto	psy ormed2	P	rior to co eath?	mpletion of cause of
ician: The certificate rector, pag	Be Co	25. Was case referr	red to medical				26. PI	ace of Death (Check		2 1	No1 1	☐ Yes	2 L No
Physici this cer ral direc	ပ	examiner? 1 Yes 2					nt 3 🗆 DOA Othe	er: 4 Nursi	ng Ho	me 5 Res	idence	6 Othe	r (Specify)
ling Pl	Certificate:	27. Manne of Deat 1 Natural	5 Pending	28a. Date of in (Month, D	ijury Day, Yea <i>r)</i>	28b. Time of injury	work	yat <br Yes 2 □ No		28d. Describe	how inju	iry occurre	d	
Attenc r death ctor: ,	rtific	2 Accident 3 Suicide 4 Homicide	Investigat 6 Could not determine	be 28e. Place of I			eet, factory, office	res 2 🗆 No	\rightarrow	28f. Location (Street a	nd Numbe	r or Rural	Route Number,
ral or / s after al Direc	I Ce	4 🗆 Homicide	determine	building, e	etc. (Specify	v)				City or To	wn, Stat	e)		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1		nysician: To the best miner: On the basis of										ed. use(s) and manner stated.
the lithin 2 the long	Me	only one) 3 29b. Signature and		urse Practitioner: To	the best of r	my knowledge	, death occurred at t		and pla	ace, and due to		se(s) and ma ate signed		
F 3 F 8		> Kus	1 ble	COTI	2				9		8.	- 16 -	201	2
3		30. Name and addr	ress of person who	o completed cause of	death (Item	n 23a) (Type, I	DOO S	Ц.		<u> </u>	-1		~~	11
W		Kuth (allati	7 2401	Bran	ndovm	III BVa	1220	(Tubi	ills	MIC	2 0	11054
Stat	е	31. Date filed (Mont	115 2 1 20	3 Regis	trar's Signa	е	Mad							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dear Physician/ AUGUST Medical 4a. Facility Name (if not institution. give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ashinston 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 385-50-2913 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent 55 Dec. 19, 1956 NY 28a-f show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No York Stewartstown PA ö 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? must be Funeral items 23a Scarborough Fare <u> 17363</u> U.S.A. death \ Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ö þ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ir than " Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Electronic Engineer Defense Contractor other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o 2 Clayton C. Mezger Dorothy M. Kemp Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 3 Scarborough Fare, Stewartstown PA 17363 Catherine E. Mezger/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of competery, cromatery or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 X Removal from State 28, Auq. Donation 5 Dother Specify 2012 New Freedom, PA st Cemetery ture of Funeral Serv 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Main Stewartstown, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine and the burial-trai resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P,O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day 2 No be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ÎNO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform after death.

Director: After this certificate | 1 ☐ Yes 2 ☐ No 2 1 Yes or Attending Physician: 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) xammer? Yes Hospital 2 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the be eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day) 12

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

01

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Month 8 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Mandrin House Anne Arundel Harwood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min Director 249-78-7621 69 1 □ M 2 🗓 F 7/26/1943 Tennessee Usual Residence of Decede of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Gambrills MD Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21054 USA 2120 Johns Hopkins Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Claim Supervisor Medical Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy important: If item 27 is marked oth any Injury or other transmit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Millard Floyd Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 Johns Hopkins Rd., Gambrills, MD 21054 Edward E. Neese / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Lakemont Mem. Gards. 8/13/2012 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 6512 NW Crain Hwy., 20715 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death a 🗀 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been significate has been significated and a funeral director, page 2 should I 1 Tyes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 🗌 Yes 1 Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No æ 26. Place of Death (Check only one) CAREG Other: 4 Nursing Home 5 Residence ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral c 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title o 29c, License number 10 30. Name and address of person who completed c use of death (Item 23a) (Type, Print) W

State Registrar 31. Date filed (Month, Day, Year) AUG 15 2012

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Midwle, Last) 2 Date of Death Physician/ Augus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heart Homes at Bay Ridge Annapolis Anne Arundel 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 219-94-8507 Director 1 □ M 2 1 F Yrs. 05/25/1925 Argentina 87 Usual Residence of Decedent silvers to the Hygiene.
Is marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show reumatic event, the Medical Examinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel West River 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4304 Rousbys Run 20778 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 02 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Santos DiBlasi Paula Corso should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 Rousbys Run West River, MD 20778 permit. Page 1 and 2 sha Department of Health en Important: If item 27 Is Edward Passerini Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Atlantic Crematory 08/16/2012 Glen Burnie,MD Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death END Stage Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease un injuly) that injusted executives. Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nsRajapatheMD 00057465 8/15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAPARAMO 2835 SmIM N -

Registrar

State

31. Date filed (Month, Day, Year)

AUG 2 0 2012

32 Registrar's Signature

5202

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 17 ay Rosemary McDermott Parker 2012 3:28 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Director 577-34-3720 83 1 🗆 M 2 🛣 F 04/12/1929 Kentucky 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 2507 Painter Court 21401 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 XWidowed 4 ☐ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home it. Page 1 and 2 should be filed wi rrtment of Health and Mental Hygie ortant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Felix McDermott Louise Mary Bricking 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Taylor/Daughter 1631 Millstone Drive, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 1 Burial 2 X Cremation 3 Removal from State 08/19/2012 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ 040 ANG Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical 29a. Certifier 1/🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 72199 8117 6 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATE 2000 Medical Parkway, Suite 607, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 2012 Registrar's Signa State Registrar

andon James	Pug	lise Sta	ate of Maryland / D					ible.	
		1- For Stata Registrar		Certificate c	of Death			1 No. 201	2 2848
Physic Medical Exam		Decedent's Name (First, Middle Landon James P	/				2. Date of Death Month I August 25,		3. Time of Death 1055 hrs
S. J.		4a. Facility Name (if not institution	_		4b. City, Town, or L	ocation of Death	August 25,	4c. County of Deat	
		Anne Arundel Medical			Annapolis			Anne Arunde	
Funeral Director				yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei	an
Birootoi		588-89-5053 Usual Residence of Decedent	1X M 2 F 0	Yr	s. 3 30°		04/26/2	2012 C	ountry) MD
any		10a. State 10b. County	10c	. City, Town or Loca	tion				10d. Inside City Limits
Maryland 28a-f show d at once.	5	MD Anne	Arundel C	rofton					1 Yes 2 No
Maryli - 28a-f	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
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ath wi	Funeral	11. Marital Status 1 X Never Married 2 Ma	12. Was Decedent Ever	lf.	as Decedent of Hispa Yes, specify Cuban, I			14. Race - Amer White, etc.	ican Indian, Black,
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d with giene.	Ę	17. Father's Name (First, Middle,	Last)	n/a	18	Mother's Name	(First, Middle, Ma	n/a	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be	Scott Andrew					Marie Mi	,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationsh						er, City or Town, State	
MD and 2 sho salth and 2 is em 27 is raumati		Jessica M. Pug.			Forest Hi			on, MD 21	
Baltimore, oermit. Pages I ar Department of Hes Important: If ite injury or other tr		1 Burial 2 X Cremation	3 Removal from State	crematory or of	her place)	· 1			
Itim it. Pag ritmen ortant y or o		4 Donation 5 Other Special Signature Luperet Service L		Metro Cre	ematory Name and Address o	8/28	3/2012	Baltimore,	MD
Ba Depa Imp				6.5	512 NW Cra	in Hwv.	II runer Bowi	ат ноте е, MD 207	15
be executed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sudden Unex Due to (or as a consequent b. Due to (or as a consequent c. Due to (or as a consequent d.	nce of): nce of):					Death
be exe ician a	dical	X UNPENDED	☐ AMENDED 23a, 2	7,28a-f,p	er me,g932	2 10-19-	12 sm		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the death certificate bas been signed by the attending physician and oppletely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at time	2 Fe	tal death 3 her (Specify)	Ectopic pregnan	су	23d. Date of delivery Month E	Day Year
P.O. es that the signed by be detach	Ď	Part II. Other significant condition	ons contributing to death but	not resulting in the u	inderlying cause give	en in Part I.		cco use contribute to 2 V No 3 Prob	
Division of Vital Records, P.O. at or Attending Physician: The law requires that the set of each. After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed						24a. Was an autopsy performe	prior to o	topsy findings available ompletion of cause of
Vital Reysician: The his certifical director, pa	Be	25. Was case referred to medical examiner?	Hospital: 1 Innatient 3			Death (Check or			
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nding Phyth.	ë	1 Natural 5 Pendir	(Month, Day, Year)	28b. Time of I	1 Vac		:8d. Describe how I nknown	vinjury occurred	
Divisior pital or Attend ours after death ours Infrector:	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide	igation 10 8-25-12 28e. Place of Injury -		.5 am et, factory, office build	ding, etc. 2	8f. Location (Stre	et and Number or Ru	ral Route Number, City
Divis To the Hospital or A within 24 hours after To the Fuorral Dire completely filled in b	Medical Co	29a. Certifier (Check only 1 Certifying Phy	vsician: To the best of my know	wiedge, death occur	red at the time, date	and place, and d	Crofton, ue to the cause(s the time, date and) and manner as state	ed.
To T	Med	29b. Signature and title of certifier	and manner stated.		29c. License n			9d. Date signed (Mor	
		Pot	- 4000 ·		O.C.M.	E.		August 26, 2012	,
	}	30. Name and address of person w	ho completed cause of death	(Item 23a)					
CH		Patricia Aronica-Pollak			900 W. Baltimo	re Street, Ba	ltimore, MD 2	21223	
St Regist	ate	31. Date filed (Month, Day Year)	2012 32. Registrar's Sig	gnature 6.	- 11 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROY Month Year ZO17 Rakes 5:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Arundel Center Annapolis, MD 21401 Anne Avunda 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X**□ M 2 □ F Apr. 29, 1922 Director 225-26-5842 90 Hours virginia Virginia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. attriber 15 is marked other than "natural", or items 23a or 28a-f show ant; If items 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 903 Placid Court 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Insurance Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Anne Bouldin Peter J. Rakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Placid Court, Bowie, MD 20716 Ann P. Rakes/wife Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Neurial 2 Cremation 3 Removal from State Lincoln Cemetery 8-16-2012 Brentwood, MD Donation 5 Other (Specify) neral Service L Beall Funeral Home Signature 22. Name and Address of Facility 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acute myocardial intarction disease or condition days Medical resulting in death) Due to (or as a consequence of) Examiner 8days. Pheumonia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart tailure Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 6 brillation 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ 1√0 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death

To the Hospital or Attending Physician. The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran Division of Vital Records, P.O. Box 68760 signed by the atte peen eral Director: After this certificate has I filled in by the funeral director, page 2 s within 24 hours a

To the Funeral C

28a-f show

Baltimore, Maryland 21215-0036

Certificate: Medical

10

29b. Signatur and title of certifier

5 Pending

AUG 15 2012

Investigation 6 Could not be

determined

1 D Natural

4 - Homicide

29a. Certifier (Check

31. Date filed (Mo

Accident Suicide

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

1 W Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

00063682

29d. Date signed (Month, Day, Year) 08/12/2012

21401

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Valerian . Bead - 7000 Medical 2000 Medical Parkway, Annapolis MD

Registrar's Signa

State Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 72012 AACO HEALTH DEPT ONH Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 17, Day 2012 8:19 \mathbf{P} M R. Renfore Renfroe James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours (Month, Day, Year) 263-28-0164 1 🖁 M 2 🗆 F **Director** 89 02/08/1923 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2X No MD Anne Arundel Annapolis 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21403 USA 7101 Bay Front Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after oment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Corprorate Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bama Mae Royal John H. Renfore Renfroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Elm Ct. Libertyville, IL 60048 Scott Renfroe (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 8/20/2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fungal Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ounds disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause (Disease or injury that initiated events Due to for as a none To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit resulting in death) Last Due to (or as a consequence of) physician s the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? be detached for Month Day 5 Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature of certifier

Registrar
DHMH 17 Rev 06-2011

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State

31. Date filed (N

address of person who com

			For State	State of Ma	ryland / Depa	artment of H	lealth and	Mental Hy	giene 20	112 28492
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tiricate of L	<i>Death</i>	2. Date of Dea	Reg. No.	3. Time of Death
markey.	Physicia Medic		THELMA CARTELL SI					AUGUST	17 ^{Pay} 20	012 10:20 P M
	Examir	ner	4a. Facility Name (if not institution, give s 324 BEACHSIDE DRIV			4b. City, Town, or	Location of Death	1	4c. County	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	N ANNE 'S 9. Birthplace (State or Foreign
	Director		212-26-1813 1 Usual Residence of Decedent] M 2 🗓 F	39 Yrs.	Months Days	Hours Min.	(Month, Day 03/24/1		MARYLAND
	land show d at	Į.	10a. State 10b. County		10c. City, Town or Loc	cation		100/-1/1		10d. Inside City Limits
	Mary 28a-f notifie	Director	MD QUEEN ANI	NE'S	STEVENS					1 ☐ Yes 2 🛣 No
	vith the 23a or st be		10e. Street and Number 324 BEACHSIDE DRIV	717		10f. Zip Code	,		10g. Citizen of W	,
	leath v	Funeral		12. Was Decedent Eve	er in U.S. 13. V	2166 Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-		D STATES American Indian,
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	0	Yes, specify Cubar Yes 2 X No		Hican, etc.)		k, White, etc. WHITE
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Man	2 should be th and Menta 27 is marked traumatic e		19a. Informant's Name/Relationship (Typ		I	g Address (Street a				
re,	E E		KAREN D. M. SMITH 20a. Method of Disposition	/ DAUGHTE	R 324 I	SEACHSIDE	DRIVE,	STEVENSV Date		D 21666 City or Town, State
imo			1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crem INDIAN MOU	atory or other place			ROMNEY,	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee							RAL HOME, P.A.
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Division of Vital Records,	eath. or: After the funer	Certificate	27. Manner of Death Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Y	(ear) 28b. Time of injury	28c. Injury : work? M 1 \(\sime\) Y		28d. Describe ho	ow injury occurred	t.
Divis	Hospital or Attending Physician: The la At burns after death. Funeral Director After this certificate he etely filled in by the funeral director, page		4 Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, stree Specify)	et, factory, office		28f. Location (St City or Town		r or Rural Route Number,
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	vith com		29b. Signature and title of certifier Moum U	rulsh W	M.D.	29c. License r	m	2	_	(Month, Day, Year) 0 - 2012
	M		30. Name and address of person who con 125 Shoveway 1	npleted cause of deat		int) Thomas town.	MD Wals	2165	8	
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			_ State	Maryland / [Department of		/lental Hyg	iene	00100
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-	Examil	ier				or Location of Death		4c. County of Death	
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	Director		579-38-1439 1XIM 2 🗆 F	82	Months Days	Hours Min.	(Month, Day,	Year) Cour	ntry)
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	ryland -f sh	턍	10a. State	10c. City, Town	ederick				10d. Inside City Limits
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	10e. Street and Number	11					1 🗆 Yes 2X No
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<u>8</u>	rs aft ral", Exar	edt	3 C Widowed 4 □ Divorced If Yes, Give Year or Dates		1 🗌 Yes 2 ဳ No	Specify:		Specify: Wh:	ite
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Baltimore, Maryland 21215-0036	i and 2 should be file Health and Mental F tem 27 is marked o ther traumatic eve		Debra Dove / Daughter					City or Town, State, Zip (ermantown, M	
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B 1	#	ine		as a consequence o	nf):				
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NIS.	or At	Certificate:	4 Homicide determined 28e. Place of Ir	njury - At home, farr etc. <i>(</i> S <i>p</i> ec <i>ify)</i>	m, street, factory, office	:	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	pital Durs a eral L		29a. Certifier 1 Certifying Physician; To the best of	-6					
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	. 750		> His Line	D		(83	23		
		ŀ	30. Name and address of person who completed cause of	death (Item 23a) (T				00/11/1	2012
	4		DR. Hairing Liang		Jest 7+1	1 St 1	Freder	ick mix	21701
	Stat	_	31. Date filed (Month, Day, Year) 32. Regist	trar's Signature					, , , , , , , , , , , , , , , , , , ,
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edical Exami		Steven Vincent Stone, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc	August 15	4c. County of Death
		2403 Harpers Ferry Road Sharpsburg		Washington
Funeral			If Under 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Birthplace (State or
Director		, , , , , , , , , , , , , , , , , , ,	Hours Min. Nov. 2	3, 1979 Foreign Maryland
	-	Usual Residence of Decedent		
any.	ŀ	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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faryland 28a-f show Latonce.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Country?
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	듭	203 Potomac Street 21713		USA
with ns 23 be no	區		nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
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after	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No s		Specify.
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5-0036 led within 72 Hygiene. other than '	Completed	12	Mother's Name (First, Middle,	Maiden Surname)
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be C	Steven Vincent Stone, Sr. K.	athy Brubaker	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	9	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Address)	nd Number or Rural Route Nur	nber, City or Town, State, Zip Code)
MD and 2 shot alth and 2 shot and 2 shot and alth and an 27 is a sum affects.		Angela Stone - Sister 622A Apple Ave		
		20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemet crematory or other place)		20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Mt. Olivet Cemeter	у 8-20-2012	Frederick, Maryland
Baltimo permit. Page Department or Important: injury or oth		21. In nature of Funeral Service Licensee 22. Name and Address of	Staurrer	Funeral Home
. 5 9 4 1		Maron Gamelle Colline 1621 Opossu	mtown Pike, F	rederick, Maryland 2170
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sur failure. List only one cause on each line.	ich as cardiac or respiratory an	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death
		h		
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (unsease or injury that initiated purplet resulting in death). Last Due to (or as a consequence of):		
kecuted n and - transit		events resulting in death) Last Due to (or as a consequence or). d.		
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60, ate be hysica e buri	Me Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Mon				Month Day Year
OX eath c atten for us	Sic	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown		
P.O. Be that the de ned by the detached f	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23e. Did t	obacco use contribute to the cause of death?
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ords, aw requir as been si 2 should b	etec		24a. Was	
COT e law e has l	Completed		perfo	death? 2 No 1 Yes 2 No
zal Recian: The certificate		25. Was case referred to medical 26.Place of	f Death (Check only one)	2 10 10 2 10
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. After this certificate has been signed by filled in by the funeral director, page 2 should be detack) Be		ther Nursing Home 5	Residence 6 🗸 Other: Scene
of Ving Phy	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury 2		how injury occurred
on sath.	흁	1 Natural 5 Pending Aug 15, 2012 1755 hrs 1 Yes	s 2 No Dilver auto	fixed object collision
ivisi or Att after de Direct	<u>i</u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office built	or Town.	Street and Number or Rural Route Number, City State)
DIVIS Hospital or A 24 hours after Funeral Dire tely filled in B	Certification:	4 Homicide determined (Specify) Lpcal Street	2403 Harper	s Ferry Road, Sharpsburg, MD
To the Hos within 24 h To the Fun completely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, d	and place, and due to the cau	se(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d and manner stated. 29b. Signature and title of certifier 29c. License n		29d. Date signed (Month, Day, Year)
	_	250. Signature and alle of certifier		August 16, 2012
		0-101		
£.		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore S	Street, Baltimore, MD 2	1223
	tate			
Pagis		nou Denistra		

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katharyne Addust Sullivan 20 1°2 2155 Medical р 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 111-50-0587 1 M 2 X F 48 July 1964 New York or than "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director VA. Loudoun Leesburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17567 Tobermory Place 20175 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ğ 1 Never Married 2 x Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Psychiatrist Medical permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If Item 27 is marked othe eny injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Anne Linck <u>Wirt</u> W. Chaney 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Thomas Sullivan-Tobermory Place Leesburg VA. 20175 <u> 17567</u> 20a. Method of Disposition r 16, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) s cemetery crematory or other place)
t. Johns
tholic Cemeter Aug Leesburg, VA. 2012 Cemeterv 22. Name and Address of Facility Loudoun Funeral Chapel 21. Signature of Funeral Service 158 20175 Catoctin Cr. SE Leesburg VA. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ead ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate rame. Finter Uniterlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ng physicien and es the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physicien I for use es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Month Day ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has a funeral director, page 2: 1 🗌 Yes 2 🗎 No ☐ Yes 2 No 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: A completely filled in by the f Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 06-2011 nsta

AUG

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month S Physician/ 7:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>498 FERRY POINT ROAD</u> ANNAPOLIS ARUNDEI Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Days Months Min. (Month, Day, Year) Hours Director 213-38-5204 1 XM 2 □ F Yrs. 3/13/1938 NORTHERN IRELANI 74 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 498 FERRY POINT ROAD 21403 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 4 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 1959 Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 CLOTHING BUYER MENS CLOTHING æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOHN STARRS SARAH MCDAID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN STARRS/WIFE 498 FERRY POINT ROAD, ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State MEMORIAL 8/17/2012 4 ☐ Donation 5 ☐ Other (Specify) DAVIDSONVILLE, MD 21. Signature of Funeral Servi 22. Name and Address of Facility ELFENBETRATENEÚNA 814 BESTRATENEÚNA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or I that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specific 2 No Hospital Other: မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one WY) 10

Registrar

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Name and address of pe

31. Date filed (Month, Day, Year)

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AUG 15 2012

ngleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

ENTA WO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Daniel Lee Shrover Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMRMC Cumberland, MD Allegany 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours Director 220-30-8589 1**X** M 2 □ F 84 Feb. 12, 1928 Maryland show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany 1 Yes 2 1 No Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18502 Martin Run Rd 21532 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Black, White, etc Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12)
Unknown College (1-4 or 5+) Timber Cutter Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Unknown Ruth Smith (Shroyer) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Cutter 20600 Hersick Rd., SW, Frostburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Pk Aug 28, 2012 Cumberland, MD ature of Funeral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of -tran that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-1 Physician/Medical death certificate be Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 | Yes | 2 | 9 | Unknown the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 2 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to a in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 27,2012 August

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Registrar
DHMH 17 Rev 06-2011

Vikramaditya Poonai, M.D., 924 Seton Drive, Ste. 2, Cumberland, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EMILY RUTH CROUCH THOMPSON AUGUST 2012 0547 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S EMERGENCY CENTER QUEEN ANNE'S QUEENSTOWN Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min **Director** 216 24 0642 1 M 2 X F 84 10/17/1927 MARYLAND Usual Residence of Deceder 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified MD QUEEN ANNE'S 1 Yes 2X No GRASONVILLE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 703 PERRYS CORNER ROAD 21638 UNITED STATES items Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner murry or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WALTER CROUCH CATHERINE KERSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHY LANTZ / DAUGHTER 709 PERRYS CORNER ROAD, GRASONVILLE, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. STEVENSVILLE CEMETERY: 08/20/2012 | 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD uncra Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Interval Between Immediate Cause (Final Physician/ oronary Sease eart disease or condition resulting in death) ay Medical Due to (or as a consequency of) **Examiner** uperten sion acreral Vears Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (oreis a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical P.O. Box 68760 the as 1 the attending IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer Records, 1 Tes 2 No 3 Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autonsv performed? Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other: ျ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accider
Suicide 5 Pending 1 Yes 2 No Accident the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

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29b. Signat

re and title of certifie

MARGARET D. MALARO,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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Registrar DHMH 17 Rev 06-2011

State

2012 32. Registary Signature B. Janes

D0055127

202 COURSEVALL DR., CENTREVILLE, MD 21617

29d. Date signed (Month, Day, Year)

2012

			1 - State of M Registrar		artment of Health and tificate of Death		ne_2012 28499	3
f	Physicia		1. Decedent's Name (First, Middle, Last) Cornelia Margaret	Terhune		2. Date of Death	Pay 2 2 3. Time of Death 3:49A M	
- Sang	Medic Examin		4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital Frederick					
	Funeral Director		5. Social Security Number 154-03-3776 6. Sex 1 □ M 2 🗵 F	e (In yrs. last birthday) 95 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 25,	9. Birthplace (State or Foreign Country) New Jersey	7
	ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or Loc Frederi			10d. Inside City Limits 1XX Yes 2 □ No	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 2501 Catoctin Court		10f. Zip Code 21702	10g.	Citizen of What Country?	
980			11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No If	Jusa Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 ▼ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white	
21215-0036			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give k	ent's Usual Occupation ind of work done during most of wor o NOT use retired) aker	life 16b	Own home	
Maryland			17. Father's Name (First, Middle, Last) Peter Allman			ne (First, Middle, Maide nna VanHout		
, Man			19a. Informant's Name/Relationship (Type, Print) Bryan Terhune – son	- 1	g Address (Street and Number or Ru chanan Road, Bla			
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Penation 5 □ Other (Specify)		atory or other place)		Location - City or Town, State terson, New Jersey	
Balti	permit. Departr Importa any inju	Č	21. Signature of Funeral Service Licensee .	//	Name and Address of Facility St. 21 Opossumtown P			02
	Medical Examiner	iner Due to lor as a consequence properties of any leading to immediate but to immediate b					Approximate Interval Between Onset and Death Zays	
Box 68760	e death certificate be executed the attending physician and shed for use as the burial-transit	by Physician/Medical E	d	2 🗌 Fetal death 3 🔲	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	_
Records, P.O.	Il or Attending Physician: The law require after death. Director After this certificate has been side in by the funeral director, page 2 should I	Completed by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause given in Part I.	1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of	,
al Rec		Be Com	25. Was case referred to medical examiner?		26. Place of Death (Chec		No 1 Yes 2 No	
Division of Vital		Certificate: To E	1 Yes 2 No Hospital: 1 Apaptite 27. Namer of Death 1 Natural 5 Pending 2 Accident Investigation 1 Month, Day		Other: 4 Nursing H 28c. Injury at work? M Yes 2 No	ome 5 Residence 28d. Describe how inj		1
Divisi			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injubil building, etc.	ry - At home, farm, stre (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)	
	the Hospi nin 24 hour the Funer npletely fill	Medical	only one) /3 Certifying/Nurse Practitioner: To the	camination and/or investi-	gation, in my opinion, death occurred a death occurred at the time, date and p	at the time, date and pla	ice, and due to the cause(s) and manner state	ed.
7	70 Wit Cor		29b. Signature ship title of Certifier		29c. License number	8 Au	Date signed (Month, Day, Year)	
	3							
- 12	Stat Registra		31. Date filed (Month, Day, Year) AUG 20 2012 32. Begistra	r's Signature	arles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28500 for State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death August 12, Day 2012 Year Kenneth R. Tinkelenberg 4:06 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 3904 Napoleon Place Bowie Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours 219-54-5207 62 1 X M 2 - F Dec. 1, 1949 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 3904 Napoleon Place USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 🗆 Widowed 4 🗆 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications Sales Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Dowell Chester John Tinkelenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline L. Tinkelenberg 3904 Napoleon Place, Bowie. MD20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory 8-14-2012 Baltimore, MD 4 Donation 5 Other (Specify) Beall Funeral Home 21. Signature of Juneral Service Lice 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) ears Due to (or a consequence of): ve ars 23d. Date of delivery Month Dav Year se contribute to the cause of death?

29d. Date signed (Month, Day, Year)

Ph. sician/ Medical Examiner

Physician/

Examiner

Funeral

Director

show

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area.

Medical

Director

Funeral

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Completed

Be

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MD

Examine for use as the burial-transi attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis signed by the at 2 Completed page 2 filled in by the funeral director, Be (မှ Certificate:

Division of Vital Records, P.O. Box 68760

Sequentially list conditions.	TATION VOLUME CONTRACTOR		
ill any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for de a consequence of:		
that initiated events resulting in death) Last	c. Due to (or as a consequence of): d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	Hivery Day Year
Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
		autopsy prior to performed?	topsy findings available completion of cause of
25. Was case referred to medical examiner?	26. Place of Death (Chec.	k only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residence 6 Other (Spec	cify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ru City or Town, State)	ral Route Number,

DHMH 17 Rev 06-2011

State

Registrar

completely

Medical

29a. Certifier

(Check only one 29b. Signature

31. Date filed (Month, Day, Year)

AUG 15 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.